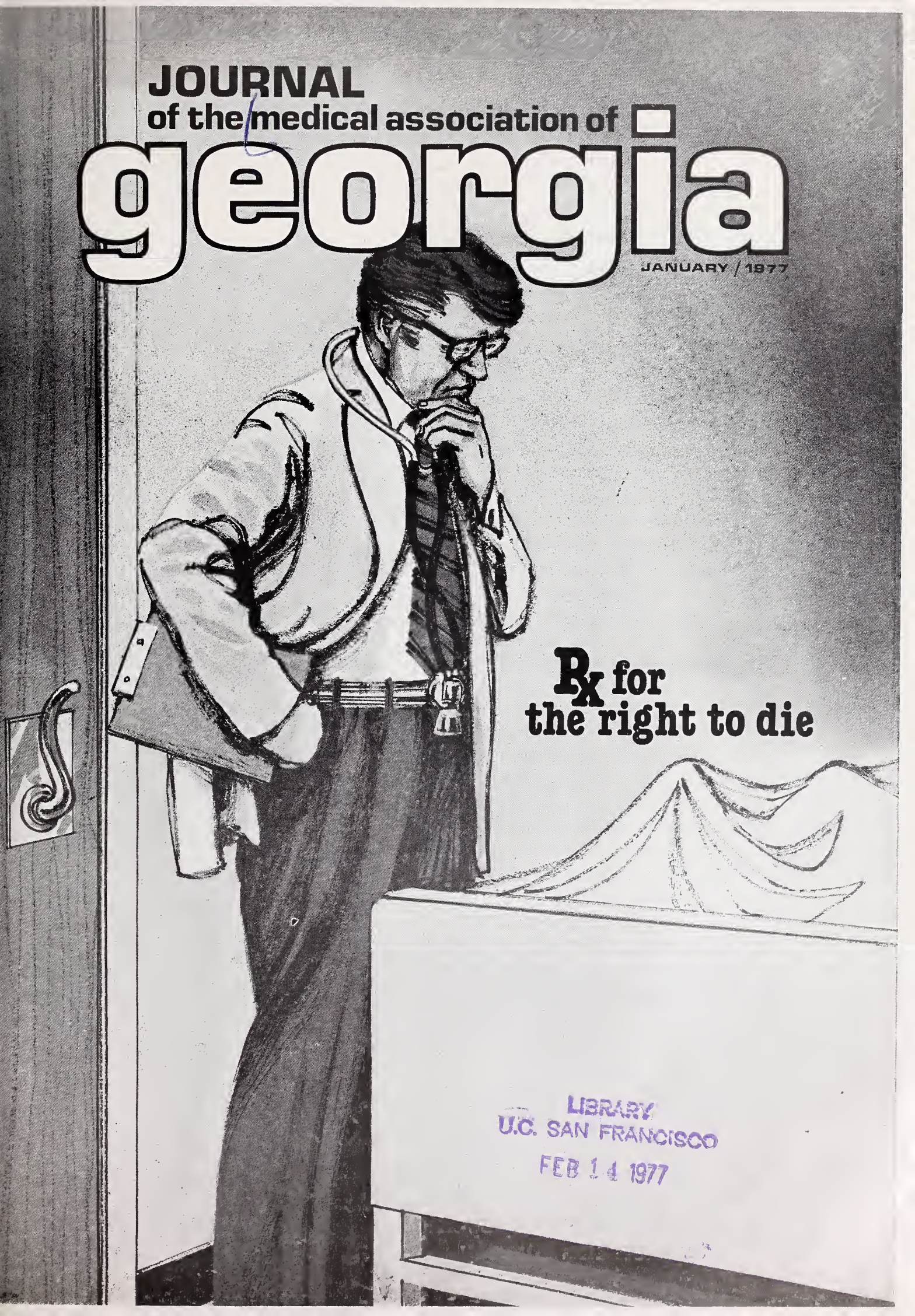
Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmedical66medi

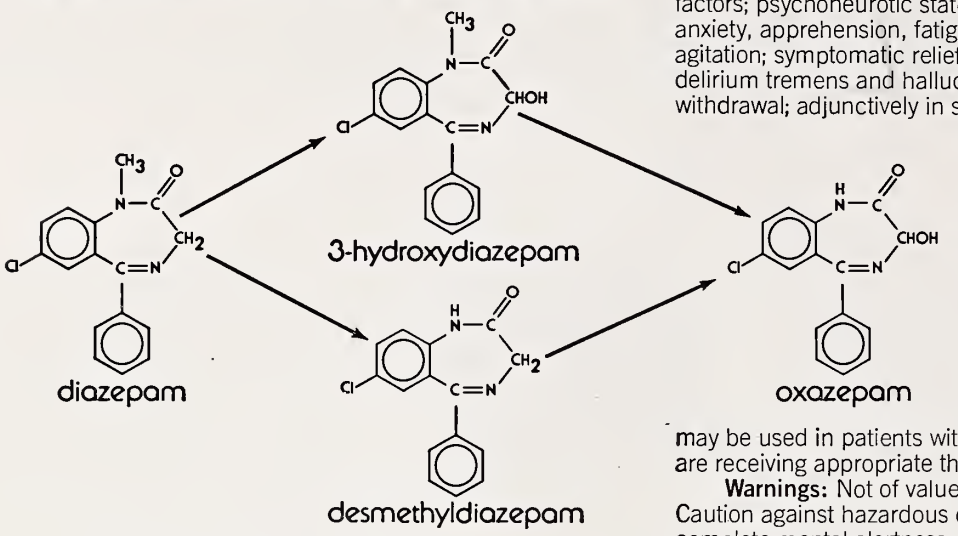
JOURNAL
of the medical association of
georgia
JANUARY / 1977



Rx for the right to die

LIBRARY
U.C. SAN FRANCISCO
FEB 14 1977

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

WEIGHT WATCHERS

2639 North Decatur Road
Decatur, Georgia 30033

For class information in the Atlanta area call: 373-5731
Outside the Atlanta area dial free: 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1976-1977

Serving the General Insurance needs of the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, electro-convulsive therapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least two days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
Davis G. Garrett, M.D.
Henry Evans, M.D.

Clinical Psychology
Michael J. Cutler, Ph.D.
Thomas L. Cory, Ph.D.

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

R. Lindsay Shuff, M.H.A.
Administrator

339718

BRAWNER HOSPITAL, INC.

Established 1910

3180 ATLANTA STREET, S.E.
SMYRNA, GEORGIA 30080
Telephone 404 436-0081



Located in the metropolitan Atlanta area, this psychiatric hospital is staffed by the members of the Center for Interpersonal Studies, P.A. Emphasis is placed on individual and group psychotherapy on an intensive basis. Each patient is assigned a staff psychiatrist who is responsible for the planning of an individualized treatment program, coordination of the assets of the therapeutic community and a continuing liaison with the patient's family and referring physician.

A comprehensive range of services is provided. There are facilities for evaluation and intensive treatment of patients with emotional problems which can be managed in an open psychiatric facility. An accredited high school is located on the hospital grounds and efforts are made to coordinate work with the local school system.

Member of the American Hospital Association and the National Association of Private Psychiatric Hospitals.

Accredited by the Joint Commission on Accreditation of Hospitals.

Mark A. Gould, M.D.
Medical Director

William H. Benson, M.D.
Psychosomatic Medicine

Ronald C. Bloodworth, M.D.
Psychiatry

Herbert Gorod, M.D.
Psychiatry

Karl S. Mihalovits, M.D.
Clinical Director

Jesse R. Peel, M.D.
Psychiatry

Harry Porter, Jr., M.D.
Psychiatry

Frederick W. Huff, Ph.D.
Psychology

JOURNAL
of the medical association of georgia

contents

VOLUME 66, Number 1

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF COUNCIL
Fleming L. Jolley
President
Robert E. Perry, Jr., M.D., Brunswick
President-Elect, Chairman of Council
David A. Wells, M.D., Dalton
Immediate Past President
James H. Sullivan, M.D., Columbus
First Vice President
Milton I. Johnson, M.D., Macon
Second Vice President
Earnest C. Atkins, M.D., Atlanta
Secretary
Carson B. Burgstiner, M.D., Savannah
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Ronald F. Galloway, M.D., Augusta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

17 Hospital Acquired Infections and Antibiotic Sensitivity
William E. Mitchell, Jr., M.D.
David T. Watson, M.D.
Carol Mims, R.N.

21 A Health Screening Clinic
Edgar D. Grady, M.D.

28 X-Ray Seminar No. 27: A "Snow-Storm" Ultrasound Pattern in the Uterus
C. Murphy, M.D.
R. Barlow, M.D.

SPECIAL ARTICLE

23 Thomsonian Medicine and Early Georgia Medical Societies
Gerald L. Cates, Ph.D.

EDITORIALS

30 Politics and the AMA

31 Reflections on MAG Scientific Assembly, 1976
James K. Van Buren, M.D.

FEATURES

33 I've Told This Before/ Caution Was the Watch Word
J. Morgan Kellum, M.D.

34 President's Letter: Not a Game, Just Communicating
Fleming L. Jolley, M.D.

35 Heart Page/Cardiopulmonary Resuscitation: The Challenge and How It Is Being Met
Robert P. Cunningham, M.D.

38 Legal Page/The California Natural Death Act—Some Help With Antidysthanasia
Richard H. Vincent

THE ASSOCIATION

41 New Members
41 Societies
41 Personals
42 Deaths

NEWS

20 Emory Celebrates Greek Heritage
20 GDA Diet Manual
20 Artificial Breeding of Chimpanzees
22 Stroke Area Facility
27 Symposium '77
29 Ask Medicare
32 Report on 1976 Scientific Assembly
37 Opportunities for Continuing Medical Education
40 Conference on Impaired Physicians
43 Month in Washington

THE COVER

There's a lot of controversy over who should make the decision whether or not to prolong life in terminally ill cases. Some of the pressuse is taken off the physician by the Natural Death Act passed recently in California (See this month's Legal Page, page 38). Cover design by Bob Hamill, Atlanta.

how do others avoid tax headaches? your CPA knows.



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

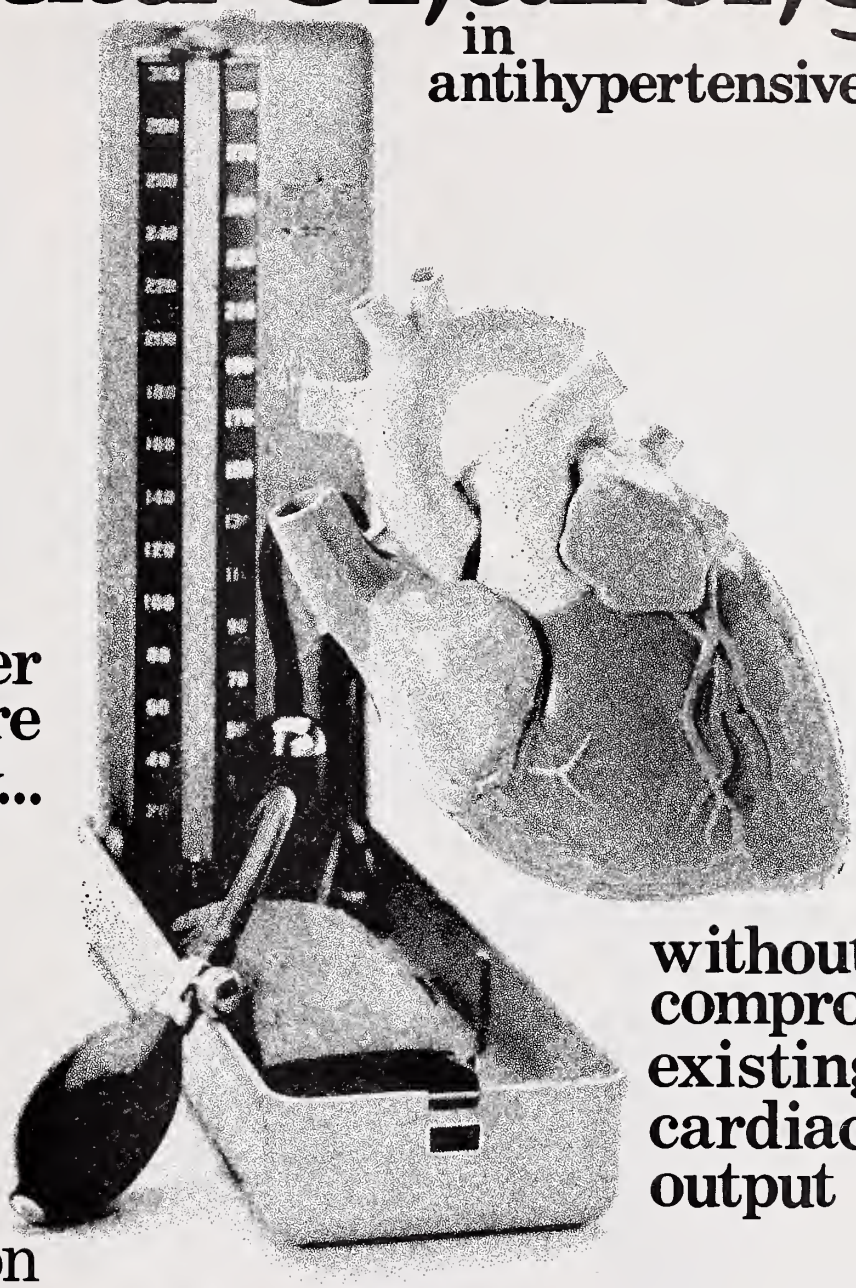
GEORGIA CPA SOCIETY

GEORGIA SOCIETY OF
CERTIFIED PUBLIC ACCOUNTANTS

4105A

A Dual Challenge

in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

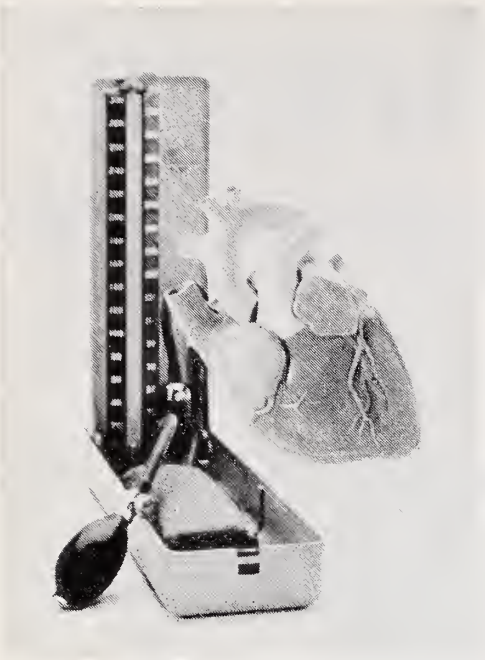
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function—cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movement occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease dail dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa i edema progresses or signs of heart failure appear.

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sor or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice liver disorders.

Hematologic: Positive Coombs test, hemolyti anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decrease libido, dermatologic reactions including eczema an lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited t 500 mg daily when given with antihypertensive other than thiazides. Tolerance may occur, usuall between second and third month of therapy; in creased dosage or adding a thiazide frequentl restores effective control. Patients with impaire renal function may respond to smaller doses. Syn cope in older patients may be related to increase sensitivity and advanced arteriosclerotic vascula disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 m methyldopa each, in bottles of 100; Tablets, contain ing 250 mg methyldopa each, in single-uni packages of 100 and bottles of 100 and 1000 Tablets, containing 500 mg methyldopa each, i single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MS representative or see full prescribing informa tion. Merck Sharp & Dohme, Division of Merck Co., Inc., West Point, Pa. 19486 J6AM07(707

MSD MERCK SHARP & DOHME

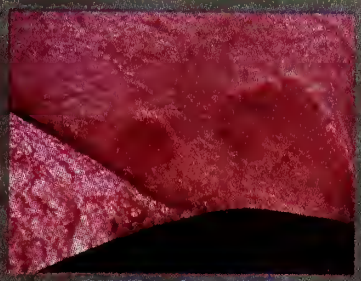
When Griseofulvin is indicated...



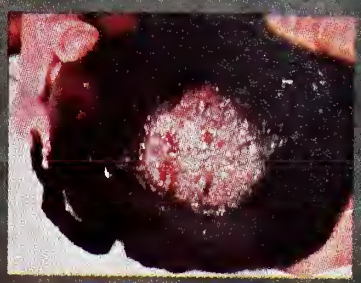
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence at this time that this confers any significant clinical difference in regard to safety or efficacy.



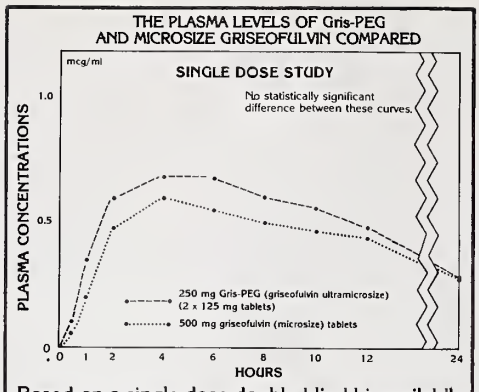
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

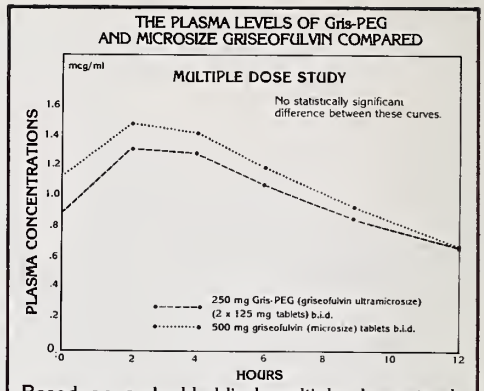
Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum, Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorIgenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium,* the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis, tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

Dorsey LABORATORIES

Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

OY-YB

20/150 H

20/100 EAR

20/70 ING IS

20/50 AS PRECIOUS

20/40 AS SIGHT HAV

20/30 YOU HAD YOUR HE

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

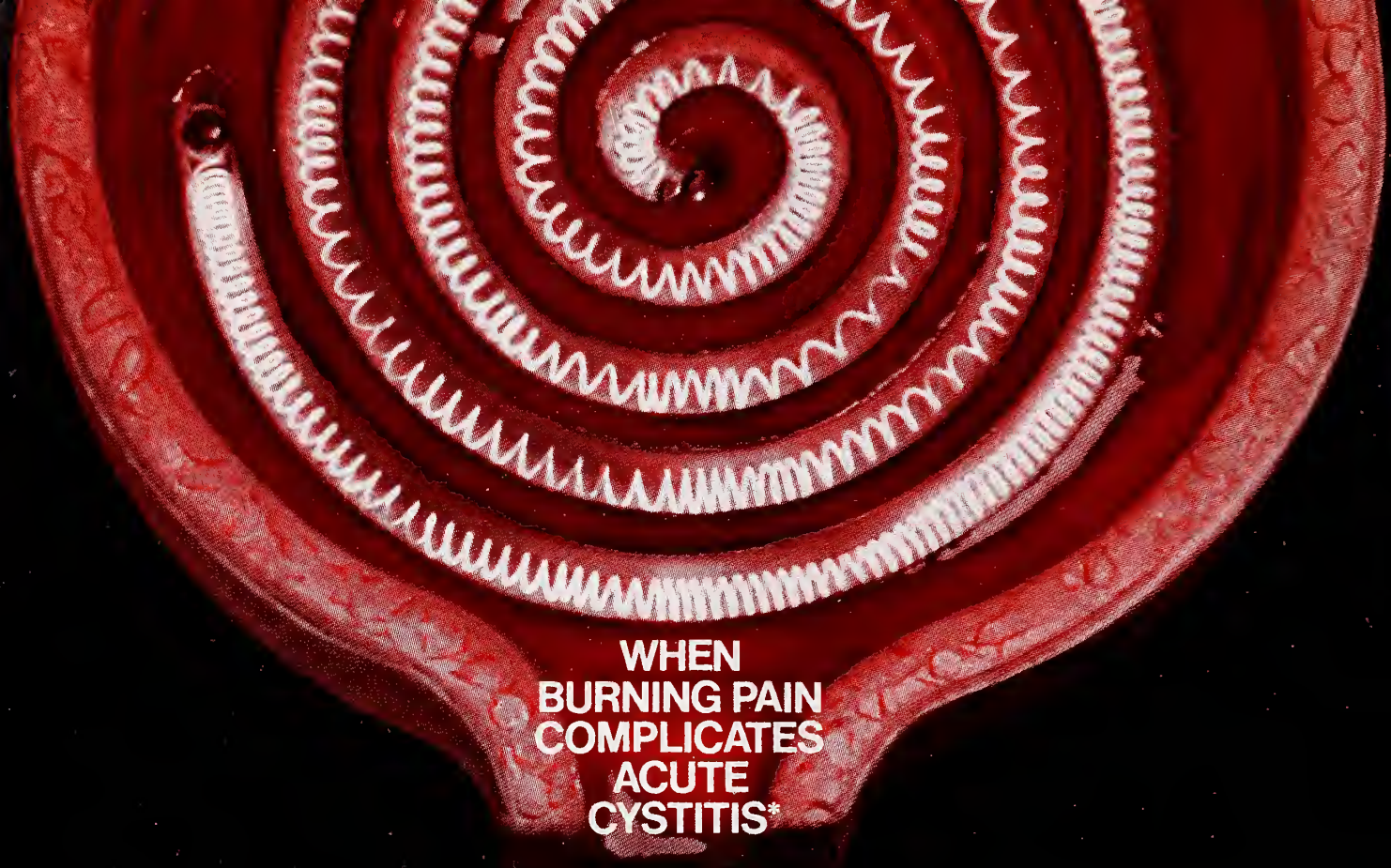
Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP



WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH

AZO GANTANOL®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

*nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris)* in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

YOU MAKE THE CHOICE.



EMPIRIN® COMPOUND c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

C III

EMPRACET™ c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

C III

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

GEORGIA BAPTIST MEDICAL CENTER
STROKE AREA FACILITY

Announces a Symposium

"STROKE—CURRENT TRENDS IN COMPREHENSIVE STROKE CARE—A TEAM APPROACH"

APRIL 1-2, 1977

SPEAKERS

Internal Medicine
Daniel Byrd, M.D.
Richard DuBois, M.D.
Edwin Evans, M.D.

Vascular Surgery
Douglas Whitney, M.D.
Pano Lamis, M.D.
Paul Stanton, M.D.

Neurosurgery
Grover Anderson, M.D.

Neurology
Charles Nicol, M.D.

Neuroradiology
Louis Martin, M.D.

Nuclear Medicine
Oliver Sorsdahl, M.D.

Nursing
Sandra Clements, R.N.
Dare Domico, R.N.

Physical Medicine and Rehabilitation
Mary Ann Kriniske, R.P.T.
Judy McDonald, R.P.G.
Wendy Perry, O.T.R.
Carol Froehlich, C.C.C./S.P.
Dorothy Cohen, M.Ed.

Community Services
Johnnie Forgay, R.N.

PROGRAM

This symposium is designed to introduce the participants to the concept of **Comprehensive Stroke Care** utilizing the team approach. The program will consist of a general session held on the first day at which presentations will include: The Team Approach in Patient Care, Rehabilitation Services, Modern Diagnostic Aids, Diseases Simulating Stroke, and Prevention of Stroke.

The second day will be devoted to **workshops** designed to discuss in depth subjects introduced in the general session to include: extracranial vascular surgery; microsurgical extracranial-intracranial anastomoses; oculoplethysmography and carotid phonoangiography; recent advances in evaluation of stroke, and rehabilitation focusing on patient and family involvement.

Registration Fees:
Physician $30
Non-Physician $20
(includes lunch)

Location:
Education Building, School of Nursing, Georgia Baptist Medical Center, Atlanta, Georgia.

For information contact Mrs. Dare Domico, R.N., Stroke Project Coordinator, Georgia Baptist Medical Center, 300 Boulevard, N.E., Atlanta, GA 30312, 659-4211, Extension 2399.

Registration closes March 23, 1977.

REGISTRATION FORM

COMPREHENSIVE STROKE CARE, APRIL 1-2, 1977

Registration fee: $.....
(If more than one registrant per agency, reduce fee by $5 for each additional person.)

NAME ..... POSITION .....

STREET ..... AGENCY .....

CITY AND STATE, ZIP .....

Please indicate your first, second and third choices for the workshop you wish to attend:

..... Extracranial Vascular Surgery
..... Intracranial Microsurgery
..... Medical Risk Factors
..... Oculoplethysmography
..... Nursing Care
..... Diagnostic Test
..... Discharge Planning
..... Stroke Club
..... Neuro Exam for Non-Medical Personnel
..... Individual Therapist (PT, OT and ST)
..... The Therapy Team
..... Establishing an Acute Stroke Unit

contains no aspirin

tablets

Darvocet-N® 100

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc.
Indianapolis, Indiana 46206

700043

JOURNAL
of the medical association of
georgia

Hospital Acquired Infections and Antibiotic Sensitivity

WILLIAM E. MITCHELL, JR., M.D., DAVID T. WATSON, M.D. *and*
CAROL MIMS, R.N., *Atlanta**

A NUMBER OF excellent references dealing with bacterial infections and antibacterial therapy are available. Most physicians are familiar with one or more such references and use them to obtain objective information for choosing among the myriad antibacterial products now on the market. A list of references found particularly useful by the authors is included in the Appendix. For the busy clinician faced with an urgent decision, however, these references may not always be readily available, or (more often) it may not be clear just how such general information can be applied to a particular case.

In an attempt to help with this problem, for the last five years the Infection Committee at Piedmont Hospital has compiled and presented infection and antibiotic sensitivity information for common hospital acquired infections. At each level of definition of the clinical problem, "likelihood of sensitivity" to each antibiotic is presented. The clinician then can consider this information along with the seriousness of the infection and the toxicities of the drugs involved to arrive at the most rational possible choice. The bulk of this paper is made up of the tables compiled for calendar year 1975.

While we make no claims of originality or infallibility, we do hope that others will find this information useful as a guide to immediate therapy, and will be stimulated to review systematically the infection and antibiotic sensitivity patterns in their own hospitals.

Procedure for the Study

Organism identification and antibiotic sensitivities are determined using standard laboratory methods. Antibiotic sensitivities are reported by the laboratory as Sensitive, Intermediate, or Resistant. In this paper, the few Intermediates (less than 3 per cent) have been grouped with Resistant. One of the authors (C.M.) is a trained nurse-epidemiologist who works 20 hours per week under the direction of the Infection Committee and the Nursing Service. She uses criteria developed by the Center for Disease Control in defining a hospital acquired infection. The Infection Committee meets at least monthly and as necessary, and plays a very active role in surveillance and control of hospital infections. To initiate the yearly review, a color-coded 3 x 5 card is prepared for each hospital acquired infection and cards are sorted by infection site. Within each category (Wound, Respiratory, and Urinary Tract), "likelihood of sensitivity" to each antibiotic is calculated for a totally unknown organism, for gram (+) cocci, and gram (−) rods. Finally, an overall sensitivity table is prepared for all hospital acquired infections where the organism has been identified but the sensitivities are not yet ready.

Despite rather confusing advertising claims to the

* 35 Collier Road, N.W., Atlanta, Ga. 30309.

TABLE 1
SITE OF INFECTION KNOWN, BUT NEITHER IDENTIFICATION NOR GRAM STAIN AVAILABLE

Likelihood of organism being sensitive to each antibiotic, by site:

Wound*	%	Urine†	%	Respiratory‡	%
Gentamycin	92	Chloramphenicol	86	Gentamycin	90
Kanamycin	82	Gentamycin	81	Chloramphenicol	83
Chloramphenicol	81	Ampicillin	63	Kanamycin	79
Keflin group	72	Kanamycin	62	Tetracycline group	71
Tetracycline group	64	Nalidixic acid	57	Colistin	65
Ampicillin	44	Keflin group	57	Keflin group	61
Erythromycin	41	Carbenicillin	53	Carbenicillin	53
Semi-syn. pens.	38	Colistin	50	Ampicillin	40
Colistin	38	Sulfisoxazole	47	Erythromycin	27
Lincocin group	36	Tetracycline group	45	Lincocin group	17
Streptomycin	36	Septra-bactrim	44		
Carbenicillin	34	Nitrofurantoin	36		
Penicillin	13	Others, under	20		

‡ Assumes Beta Strep and pneumococci sensitive to usual gram (+) effective antibiotics.
† Not tested against gram (+) cocci.
* Assumes Beta strep sensitive to usual gram (+) effective antibiotics.

TABLE 2
SITE AND GRAM STAIN KNOWN—NEITHER IDENTIFICATION NOR SENSITIVITY KNOWN
A. WOUND (Likelihood of organism being sensitive to each antibiotic)

A. WOUND

Organism—123 isolated:

Gram (–) rods	(65)	Gram (+) Cocci	(55)
E. coli	20	Staph aureus	23
Proteus	13	Staph epidermidis	14
Klebsiella	13	Enterococcus	7
Pseudomonas	8	Alpha strep	6
Bacteroides	6	Beta strep	5
Serratia	4		
Enterobacter	3		
Acinetobacter	1		

Likelihood of organism being sensitive to each antibiotic

Gram (–) Rods	%	Gram (+) Cocci*	%
Gentamycin	100	Chloramphenicol	91
Kanamycin	87	Keflin group	87
Chloramphenicol	73	Erythromycin	87
Colistin	71	Gentamycin	84
Streptomycin	68	Semi-synthetic pens.	82
Carbenicillin	63	Lincocin group	78
Keflin group	59	Kanamycin	77
Tetracyclin group	54	Tetracycline group	76
Ampicillin	46	Ampicillin	42
		Penicillin	27

B. URINE

Organisms—185 isolated:

Gram (–) Rods	(121)	Gram (+) Cocci	(64)
E. coli	56	Enterococcus	41
Proteus	24	Beta strep	10
Pseudomonas	15	Staph epidermidis	5
Klebsiella	13	Other strep	5
Enterobacter	7	Staph aureus	3
Diphtheroids	4		
Citrobacter	1		
Serratia	1		

Likelihood of organism being sensitive to each antibiotic

Gram (–) Rods	%	Gram (+) Cocci	%
Gentamycin	97	Chloramphenicol	90
Nilidixic acid	86	Erythromycin	78
Chloramphenicol	83	Ampicillin	75
Kanamycin	82	Penicillin	55
Carbenicillin	81	Gentamycin	50
Colistin	76	Keflin group	46
Sulfisoxazole	71	Lincocin group	38
Septra-bactrim	66	Tetracycline group	27
Keflin group	63	Kanamycin	23
Ampicillin	56		
Tetracycline group	55		
Nitrofurantoin	55		

C. RESPIRATORY

Organisms—114 isolated:

Gram (–) Rods	(94)	Gram (+) Cocci	(20)
Enterobacter	19	Staph aureus	9
Klebsiella	19	Beta strep	6
E. coli	13	Strep pneumoniae	3
Pseudomonas	13	Staph epidermidis	2
Haemophilus	10		
Proteus	10		
Bacteroides	6		
Citrobacter	5		
Serratia	3		
Acinetobacter	2		

Likelihood of organism being sensitive to each antibiotic

Gram (–) Rods†	%	Gram (+) Cocci‡	%
Gentamycin	98	Chloramphenicol	100
Colistin	79	Gentamycin	100
Chloramphenicol	79	Kanamycin	100
Kanamycin	74	Keflin group	100
Streptomycin	70	Semi-synthetic pens.	98
Tetracycline group	66	Erythromycin	95
Carbenicillin	64	Tetracycline group	95
Keflin group	52	Lincocin group	95
Ampicillin	37	Ampicillin	58
		Penicillin	58

* Assumes Beta strep sensitive to usual gram (+) antibiotics.
† Assumes Haemophilus uniformly sensitive.
‡ Assumes Beta strep and pneumococci sensitive to usual gram (+) effective antibiotics.

contrary, in most cases there is no clinically significant difference among chemically similar antibiotics. With this fact in mind, antibiotics have been grouped as follows:

1. *Tetracycline group:* Tetracycline, Chlor and Oxytetracycline, Declomycin, Vibramycin, Randomycin, Achromycin, Terramycin, Panamycin, Minocin, etc.

2. *Keflin group:* Keflin, Keflex, Loridine, Kafocin, Ancef, Kefzol, etc.

3. *Lincocin group:* Lincomycin, Lincocin, Clindamycin, Cleocin.

4. *Semisynthetic Penicillins:* Methicillin, Oxacillin, Cloxacillin, Dicloxacillin, Nafcillin, Tegopen, Veracillin, Staphcillin, Unipen, Prostaphlin, etc.

Results

The information is presented in a series of tables, which are arranged according to the amount of information already available to the physician. If only the site of infection is known, use Table 1. If a gram stain is available, use Table 2. If the organism is known but therapy must be given before sensitivities are ready, use Table 3.

It is obvious that proper use of antibiotics in significant infections before definitive antibiotic sensitivity results are available depends on several considerations. These include the apparent site and source of the infection, the history of recent antibiotic use, the seriousness of the infection, the likelihood of untoward reactions, and the *likelihood of the organisms being sensitive to each of the antibiotics being considered.* We have found that a knowledge of the "usual" sensitivities in common hospital acquired infections permits us to make effective use of immediate gram stains and begin therapy with a good likelihood of choosing an effective antibiotic. The antibiotic sensitivities of some common organisms are predictable whether the infection is acquired in the community or in the hospital, but for many organisms this is not the case. Further, most clinicians (including the authors) generally do not see enough hospital acquired infections to stay familar with the frequency of the various organisms and their antibiotic sensitivities when encountered. For these reasons physicians are often forced to choose an antibiotic without adequate information. This paper presents the necessary information for our 350 bed acute general hospital, with the hope that others will find our information useful, and will be stimulated to review the experience in their own hospitals. Preparation of these reports to the medical staff requires approximately four hours per month for card preparation by the nurse epidemiologist, a total of 10 hours for compilation and analysis by a physician, and five hours of clerical work. Much of this work appears to be suitable for computer handling in hospitals which have this capability.

We have noted several interesting sensitivity pat-

TABLE 3

ORGANISM KNOWN BUT SENSITIVITIES NOT REPORTED
OVERALL SENSITIVITIES, ALL ORGANISMS, ALL SITES

Drugs	Acinetobacter %	Citrobacter %	E. coli %	Enterobacter %	Klebsiella %	Proteus %	Pseudomonas %	Serratia %	Enterococcus %	Staph. aureus %	Staph. epider. %
Ampicillin	0	33	78	13	5	85	3	0	80	14	35
Carbenicillin	100	100	88	72	20	98	69	NT	NT	NT	NT
Ceph. group	0	7	85	16	64	83	0	0	11	100	100
Chloramphenicol	0	100	94	76	95	93	6	67	84	100	76
Colistin	33	83	97	88	93	6	97	67	NT	NT	NT
Erythromycin	NT	NT	NT	NT	NT	NT	NT	NT	80	100	70
Gentamycin	67	100	97	100	98	96	100	100	20	100	100
Kanamycin	100	100	95	92	93	96	11	100	11	100	54
Lincocin group	NT	NT	NT	NT	NT	NT	NT	NT	20	97	65
Semi-synthetic penicillin group	NT	NT	NT	NT	NT	NT	NT	NT	0	100	94
Penicillin	NT	NT	NT	NT	NT	NT	NT	NT	54	14	35
Streptomycin (not tested against urine organisms)	33	60	81	83	81	95	28	83	NT	NT	NT
Tetracycline group	33	66	80	78	91	15	11	33	18	100	53
URINARY TRACT ORGANISMS ONLY											
(1) Nalidixic acid	0	100	100	71	100	100	7	0	NT	NT	NT
(2) Nitrofurantoin	0	100	95	43	54	0	0	0	NT	NT	NT
(3) Septra-bactrim	0	17	98	71	100	8	0	0	NT	NT	NT
(4) Sulfisoxazole	NT	100	77	NT	85	85	7	NT	71	NT	NT

NT—Not tested.

terns which appear to be valid for Piedmont Hospital and may very well be true elsewhere as well.

1. In our hospital Ampicillin and Penicillin are poor choices for therapy of most hospital acquired wound and respiratory infections, though Ampicillin is effective in most gram (+) coccus urinary tract infections.

2. Gentamycin remains generally effective for serious hospital acquired infections of all types except gram (+) coccus urinary tract infections, even though Gentamycin's overall percentage of effectiveness against gram (−) rods has dropped slightly over the last three years from 100 percent to approximately 97 percent in 1975.

3. Carbenicillin is no longer reliably effective against hospital acquired Pseudomonas infections.

4. Chloramphenicol, due to its known toxicity, is understandably little used, but it is effective against the organisms found in most hospital acquired infections and should not be totally overlooked in critical situations.

Summary

Tables for use in choosing an effective antibacterial agent prior to the availability of definitive sensitivity data are presented. Physicians caring for patients with hospital acquired infections are encouraged to use such information and to arrange for similar data to be accumulated in their own hospitals. ■

APPENDIX
Useful References

1. Goodman, Louis S. and Gilman, Alfred: "The Pharmacological Basis of Therapeutics," 1975.
2. The Medical Letter, Volume 18, No. 3, January 30, 1976. "The Choice of Antimicrobial Drugs."
3. The American Hospital Association, "Infection Control in the Hospital," 1974.
4. Neu, Harold C.: "Antimicrobial Agents, Mechanisms of Action in Clinical Usage," Current Problems in Surgery, June 1973.

Emory Celebrates Greek Heritage

Emory University's School of Medicine was presented marble heads of Asklepios, Hippocrates and Hygeia at a ceremony held last month. The sculptures were carved of Pentelic marble by Nicholas Perantinos, one of the best known contemporary sculptors in Greece. They were a gift from John E. Skandalakis, M.D., Ph.D., professor on anatomy, clinical assistant professor of surgery and Chris Carlos Professor of Surgical Anatomy and Technique. Dr. Skandalakis, a naturalized U.S. citizen who was born in Sparta, Greece, commissioned the heads to be carved as replicas of ancient Greek statues.

As part of the same ceremony, a seedling from the Plane Tree of Cos was planted on the grounds of the Woodruff Medical Center Administration Building. According to tradition, Hippocrates taught under a tree of this type which still stands on the Island of Cos where he lived.

GDA Diet Manual Available

The Georgia Dietetic Association Diet Manual—designed for use in nursing homes, small community hospitals, local health departments and other health facilities—is now available from the GDA.

Subjects covered include: Principles of each normal and modified diet, foods included and foods excluded, plus a suggested meal plan; the vegetarian diet; the new Diabetic Exchange Lists; growth charts with reference percentiles for children; approximate composition of selected formulas and dietary supplements. The information is based on the most recent data available from the National Research Council's Food and Nutrition Board, the American Heart Association and the American Diabetes Association.

The manual, endorsed by MAG, the Georgia Health Care Association and the Board of the Georgia Department of Human Resources, can be purchased for $10 from Mrs. Terry Till, R.D., GDA Central Office, 3493 Normandy Circle, NE, Marietta, Ga. 30060.

FIRST PREGNANCY ACHIEVED IN ARTIFICIAL BREEDING OF CHIMPANZEES

Scientists at Emory's Yerkes Regional Primate Research Center have achieved the center's first successful pregnancy in an artificial breeding program with chimpanzees.

David E. Martin, Ph.D., principal investigator, said a female chimpanzee named Banana was artifically impregnated on Nov. 24, 1975, and delivery of her infant was expected in July of this year.

The Yerkes program is supported by the National Science Foundation and National Institutes of Health.

Using an electrostimulation device developed at the Yerkes Center, the researchers have collected semen from more than two dozen primate species ranging from prosimians to chimpanzees.

"We have also entered preliminary collaborative studies with physicians interested in reproduction involving spinal-cord injured human males," Dr. Martin said.

A significant number of abnormal findings was revealed. The percentage of patients with positive findings who followed up with physicians would be of interest.

A Health Screening Clinic

Held in a Community in Georgia (Riverdale), May 1, 1976.

EDGAR D. GRADY, M.D., *Atlanta**

DETECTION OF DISEASE in an early stage has been the aim of many of our medical detection and treatment programs. This is illustrated by the American Cancer Society slogan of "Early cancer can be cured." Hypertensive screens and screens for diabetes both have emphasized that such early detection can lead to early treatment and prevention of complications.

On May 1, 1976, a heterogeneous organization of several groups carried out a free general health screening program for any of the adult population in and around Riverdale, Georgia. Evaluations that could be easily done to find disease readily treated were selected. Three churches of the community (Presbyterian, Baptist and Methodist), the Clayton County Unit of the American Cancer Society and the Medical Research Foundation (a non-profit scientific corporation operating principally in cancer research at Georgia Institute of Technology) all joined together to do the screen.

There follows a copy of the screen outline and agreement which describes the activity conducted at the Riverdale Presbyterian Church. The so called "men's exam," was palpation of the prostate. The glaucoma test (tonometry) was not done. Hopefully, repetitive clinics will be held at other churches, sequentially, revised according to experience.

The summary of the examinations and findings is presented in table form here.

Summary of Health Screening Clinic

Total number examined	128
(some requested only part of examination).	
Total number of females	97
Pelvic, pap and breast exam	79
Urine for sugar	82
Blood pressure	97
Stool for blood	97 sent, 40 returned
(3 slides each)	
Self breast exam explained to	97
Total number of males	31
Prostates examined	26
Stool for blood	31 sent, 14 returned
(3 slides each)	
Urine for sugar	26
Blood pressure	26
Number of types of significant abnormalities found:	
Abnormal prostates	4
Inguinal hernia	1
Urine sugar positive (+)	2
(both females)	
Stool positive (+) for blood	6
(3 females and 3 males)	
Elevated blood pressure	8
(6 females and 2 males)	
Abnormal pap smears	7
very atrophic class I	1

RIVERDALE HEALTH SCREENING CLINIC

MAY 1, 1976

Name ..... **Telephone**.....
Address .....
Street **City** **Zip Code**

Tests for:
Blood Pressure .....
Glaucoma .....
Women's Test (upstairs):
Heart .....
Breast .....
Pelvic .....
Pap Smear .....
Men's Exam .....
Diabetes (urine specimen) .....
Colon Cancer (stool specimen) Slides and information for you to prepare this and send it in for testing will be given as you leave.
Other remarks from physicians or nurses .....
.....
I understand that this is a screening test only and it is my responsibility to follow up on it. .....

* Chairman of the Medical Research Foundation, Inc., Neely Nuclear Research Center, 900 Atlantic Drive, N.W., Atlanta, Georgia 30318.

atypical with atrophy, class II	2
dysplasia atypical, class II	2
inflammatory, atypical, class II	2
Granular cervicitis visualized (none had abnormal Paps)	5
Severe atrophic vaginal musosa (two of these also diagnosed by Paps)	3
Enlarged irregular uterus (fibromyomata)	3
Ovarian mass	3
Very large cystocele	1
Large mass in area of liver	1
Pain breast without mass	4
Breast mass	5
Irregular breast tissue	6
Lesion of gum	1

Conclusion: People in general appear interested in their health evaluation. They did take advantage of a community health service offered for this purpose. The source of their reference was as follows.

Church	47
A friend	18
A poster sign	14
Newspaper	42
Civic club	5
Miscellaneous	2
Total sources reported	128

Sixty abnormal findings were found. (More than one were present in several patients.) Each person was told verbally of the findings and also by letter sent in follow-up. A sample letter is quoted here:

Dear Friend:

We suggest that you see your doctor to follow up on the examination you had at the Riverdale Health Screening Clinic at Riverdale Presbyterian Church on May 1, 1976.

Please call your own doctor and tell him we recommend he help you follow up the following findings of your examination:

. . . . . .

. . . . . .

. . . . . .

Your screening examination was sponsored by the Churches of Riverdale, the Clayton County Unit of the American Cancer Society, and the Medical Research Foundation, with the help of the Bell-Meltzer Laboratories and General Medical Atlanta.

We appreciate the opportunity to be of service to you.

Sincerely,
Edgar D. Grady, M.D.
Chairman

Comments

Stool examination for occult blood has been valuable in detecting occult disease of the colon. If a meat free diet is given, the number of false positives is decreased; however, patients are more cooperative if instructions are simpler. About half of these slides given out were returned. In contrast, when we ran a project for the Clayton County Unit of the American Cancer Society for a colon screen the year before, only one quarter came back when these tests specified a meat free diet.

We have had trouble getting a follow-up on the evaluation of the abnormal findings. One-third of the patients' doctors gave a follow-up report. For the next screen, we must devise a better system. Probably a card will be sent to the patient, for him to have filled out by his doctor, describing his follow-up.

In general, we feel that the job was well worth while. A large amount of pathology was found and the patients were so informed. Methodology can be improved and so can the follow-up.

Thanks are expressed to the many volunteers from the churches and the American Cancer Society and to the following other physicians who helped with the examinations: David Sowell, M.D., Thomas J. Busey, M.D. and Manuel Galdos, M.D. ■

FUNDS EXTENDED FOR STROKE AREA FACILITY

Douglass Whitney, M.D., Director of the Stroke Area Facility at Georgia Baptist Medical Center, announces that funding for the stroke activities have been extended for an additional year by the Regional Medical Program. The continuation of the grant will provide for an extension of the current screening and educational programs as well as for the sponsorship of a stroke symposium early next year.

The Stroke Area Facility provides the only comprehensive stroke care in North Georgia and has a responsibility to the public and physicians in the field of acute stroke care, rehabilitation, education and screening.

A fascinating account of early Georgia medicine and the efforts to combat "irregular practitioners" through the organization of medical societies.

Thomsonian Medicine and Early Georgia Medical Societies

GERALD L. CATES, Ph.D., *Athens**

THE CHARACTER of Georgia medicine made a significant departure from its past during the first decades of the nineteenth century. The day of self-trained and apprenticed trained practitioners was rapidly ending, and a new type of physician was beginning to appear. Most early nineteenth century physicians still began their medical educations under local preceptors, but a growing number spent at least one year at a formal medical school and each year increasing numbers completed the two-year medical courses required for the M.D. degree. By the early 1830s, at least 130 degreed physicians were practicing in Georgia. After the opening of a degree program during the early 1830s, at the Medical College of Georgia at Augusta, this number would increase several fold before the Civil War.[1]

The Georgia Medical Society

As the number of degreed physicians grew, so did the need for a formal medical organization. Such an organization would allow local physicians to pool their knowledge, provide a forum for the exchange of ideas, and advise the community on epidemic threats and sanitation programs, as well as lobby for much needed health legislation. Most important in the minds of many Georgia physicians, however, a medical organization would also serve to regulate the practice of medicine within the communities. Specifically, it would combat the so called "irregular practitioners," those physicians whose sectarian medical theories contradicted those of traditional medics. Most Georgia physicians were of the opinion that the state, particularly its urban areas, was already overcrowded with physicians and that the resulting competition tended to undermine not only the individual's practice but the profession as a whole. A substantial percentage of these surplus physicians were, in the opinion of many, either incompetents or "quacks." Consequently, most formally trained physicians saw the Medical Society as an indispensible tool in the exclusion of these outlaw practitioners from the profession.[2]

Despite the obvious advantages of a statewide medical society, geographic difficulties and local jealousies made such an organization impractical before mid-century. Consequently, it was in Georgia's large towns where the earliest medical societies first appeared. Not surprisingly, the first of these, the Georgia Medical Society, was chartered in Savannah in 1804. Information concerning the Society between 1804 and 1820 is sketchy because its minutes for the period were lost either by fire in 1819 or during the yellow fever epidemic of 1820, which claimed the life of the Society's secretary. Nevertheless, we do know that it was organized on June 28, 1804 and that Dr. Noble Wymberly Jones was elected its first president; Dr. John Irvin, vice-president; Dr. Lemuel Kollock, treasurer; and Dr. John Grimes, secretary.[3] The Society immediately turned to community service by forming a committee to record the births and deaths in Savannah. This, it hoped, would aid in clarifying local medical problems.[4]

The importance of the Georgia Medical Society in Georgia history cannot be overemphasized. This group encompassed literally all of the city's formally trained physicians and provided the leadership for Georgia's medical community during much of the early nineteenth century. Not only did the Society organize local physicians and attempt to exclude poorly trained physicians from practicing within Savannah, but it also adopted the state's first code of medical ethics and drew up local fee bills in an effort to regulate prices.

It was the Georgia Medical Society that campaigned for and finally achieved a program of systematic vaccination against smallpox within Savannah; carried out topographical health surveys of Savannah and surrounding counties; founded a med-

* 480 Pine Needle Road, Athens, Ga. 30601. Dr. Cates is an ex-officio member of the MAG Ad Hoc Committee on the Bicentennial Celebration.

ical library; and conducted extensive studies of Savannah's major epidemic diseases—smallpox, yellow fever, and malaria. Probably its most important contribution was its formation of the backbone of the first systematic anti-malarial program begun in the United States, which eventually drained most of the swamps and rice fields surrounding Savannah. During the early 1830s, the program's success was reflected in Savannah's declining mortality rate.[5] Without question, the Georgia Medical Society was one of Georgia's most important medical milestones.

Despite the avowed intentions of its founders that it become a nucleus for a statewide medical society, distance between cities and the numerous medical crises confronting the Savannah area during the early nineteenth century forced the Society's attention inward. The most important of these crises was a mounting mortality caused by increasingly serious malaria and yellow fever epidemics. To defend against these growing menaces, in 1817 or 1818 the Society began to issue periodic reports during the fever months (June-September) cataloging the number and types of fevers present within Savannah and advising the public how to best deal with the situation. It was from this informal reporting system that the Board of Health arose during Savannah's first major yellow fever epidemic in 1820.[6]

The Thomsonians

In spite of the Society's important work in the areas of epidemiology and public health, by 1820 its members were equally concerned with what they felt was a dangerous increase in the number of quacks and incompetents practicing within the city. Of particular concern was the growing influence of the Thomsonians. Unfortunately, the growing popularity of such sectarian medical theories was often a direct reaction to the abuses of traditional practitioners, excessively harsh bleed, purge, and blister methods. Indeed, the popularity of many of these so called "quacks" came less from their success in curing patients' ills than from the fact that they seemed to kill fewer patients than did their formally trained competitors. The Thomsonians, for example, who most Georgia physicians considered their chief enemy, were followers of a New Hampshire farmer, Samuel Thomson. Thomson's empirical system was based largely on the use of steam, botanics, and the strict avoidance of bleeding.[7]

Samuel Thomson

The story of Samuel Thomson and Thomsonianism in America is less a tale of quackery than of a social movement. Thomson's experience and success reflected both the success of Jacksonian democracy and the bankruptcy of traditional medical practice. The Thomsonians democratized medicine to make its secrets available to the common man much as the Jacksonians placed the control of government in his hands. Indeed, the life of Samuel Thomson represented not only an example of the rise of a common man but also the frustrating and disillusionary experience of that man with traditional medicine. The very success of the Thomsonians reflected the similarity of Thomson's experience with traditional medicine and that of many of his disillusioned countrymen.

Thomson was born in 1769 on the New Hampshire frontier into a life of toil and hardship. Lame from birth and sickly by nature, his greatest love was wandering the forest near his home studying and collecting native plants. This was a love for which he had little time, however, for his father, a man as stern and unyielding as the land from which he tried to wrest a living, put him to work on the farm at age five. Afterwards, young Samuel's life consisted of little but back bending work and poverty. He hated farming and wished to study with a local root doctor. But his father would not release him from the farm and the local doctor would not accept anyone with so little education. Then several unhappy personal experiences turned Thomson completely against traditional medicine. He saw his mother die of measles in spite of the care of several local physicians; earlier, he felt he had cured himself of the same disease through the use of botanics. A year after his mother's death, his wife became severely ill following childbirth. Seven local physicians treated her, but her condition continued to worsen. As she neared death, Thomson dismissed the traditional practitioners from the case and called in two local root doctors. One day later his wife appeared completely cured.

His wife's recovery strengthened Thomson's interest in herbal medicine and in the next several years he gained a local reputation as a folk healer. It was during this period that he developed his theories on the cause and cure of disease. Thomson became convinced that all disease arose from one general cause and that one remedy could effect a cure. The cause was cold and the cure, heat. He, like the Greeks, believed, "all animal bodies are formed of four elements, earth, air, fire, and water." Any imbalance among these four elements which reduced the power of the heat resulted in illness. To effect a cure, one must restore the balance. Thomson sought to restore this balance through the use of steam baths; herbs such as peppers, mild vegetable emetics, purgatives, enemas; and sweat producing botanicals. The chief ingredient was lobilia, an emetic which grew wild in much of North America. To this he might add capsium, hemlock, bayberry, gin-

ger, or pepper, and cloves to make a concoction often referred to as "Composition Tea."[8]

Although Thomson fervently opposed bleeding and the use of mineral-based drugs such as calomel, his treatment was not always one for the faint hearted. For example, one Thomsonian prescription for a Maryland man called for the day to begin with

> a steam bath 30 minutes in duration. When the sweat rolls off as thick as your finger the body is washed with cold water and the patient straightaway put to bed with hot bricks to bring back the heat. Then a powerful vomitive is administered, composed of *bay berry,* of cayenne (red pepper) and lobilia, and all those herbs are mixed in 40 proof brandy, after which warm water is drunk until there has insured the most extraordinary vomiting.

The patient was then given a second steam bath, followed by a second cold bath, a second session in bed with hot bricks, followed by two enemas, of penny royal, cayenne pepper, and lobilia.[9]

Thomson patented his system and marketed it through representatives who traveled about the country selling copies of his two-volume work, *New Guide to Health; or Botanic Family Physician.* He then began a large scale effort to popularize his system. He was aided in this project by two individuals, his son Cyrus, who spread the gospel of Thomsonianism through New York, Ohio, and the West, and the Reverend William Fonerden, who traveled through the South preaching the gospel, Thomsonianism, and selling the right to use of *New Guide* in the home.

The Thomsonians first appeared in Georgia in 1818 when a representative, probably Fonerden, traveled through the state. Georgia physicians had faced "quacks" before but never one who received such a ready welcome or one with so well organized a following. As noted earlier, Thomsonian success resulted in part from the abuses of traditional medicine; i.e., the more serious the disease the more drastic must be the cure. Not surprisingly, Thomson's success came at the height of that theory's popularity among medical men in Georgia.[10]

Response of Georgia Physicians

The Georgia Medical Society's response was vigorous and immediate. The growing popularity of the Thomsonians after Fonerden's visit in 1818 was one factor in the society's decision to form a tribunal to examine the licensed physicians within Savannah. In 1821, the legislature passed the Savannah Licensing Act, which made the Georgia Medical Society virtually an exclusive club to which every practicing Savannah physician had to belong. The Act also made the Society the first official licensing body in Georgia. It did not require practicing physicians to take an examination but it ruled that anyone who wished to begin a practice in Savannah after 1821 must be examined by the Medical Society. We have no way of knowing how extensive the examination was, but the Medical Society minutes for the period 1821 through 1833 reveal no instance of anyone failing to receive licensure, although there were instances of examinations having to be repeated.[11] Of course, only proponents of traditional medical practice were tested.

Shortly after the passage of the Savannah Licensing Act, the Medical Society published a code of ethics to further regulate the profession. The code forbade rumor mongering among physicians and interference of any physician in a case being treated by a colleague. But most important as far as the local practitioner was concerned, it decreed that,

> No member [was] at liberty to consult with a *Quack;* inasmuch as he would prosper and support a character which he condemns—deprives his medical brothers of the advantage of their professional education, and degrades himself by mixing with ignorant and unprincipled pretenders.[12]

As already noted, the Georgia Medical Society, through its medical licensing organization, was notably lax in the movement to extend the same standards to the rest of the state. There were several probable reasons for this: (1) many considered the medical practitioners of Savannah to be afflicted with a certain snobbery, feeling themselves to be superior to more provincial interior colleagues; (2) serious medical problems confronting the city had always forced their energy and attention inward; and (3) since the city's medical standards were regulated by the Society, Savannah physicians did not feel as threatened as did practitioners in the interior. Consequently, the movement for a state-wide medical association and a state-wide licensing act came not from Savannah but from the interior.

As with the licensing movement in Savannah, it was the threat from sectarian practitioners which provided impetus for organization. Probably few central Georgia physicians felt the need for a medical society before the rise of sectarian medicine. A number of reasons explain this, but most important was size and isolation. The smaller interior towns had fewer physicians and the close personal and professional relationships which existed made a formal organization unnecessary. Also, interior towns were generally healthier than those on the coast where much of the energy which had characterized the early years of the Georgia Medical Society had stemmed directly from the immediate threats posed to Savannah by smallpox, yellow fever, and malaria. These were concrete enemies against which Savan-

nah found itself in a very real struggle for survival. The physicians of Georgia's interior towns were not so gravely threatened and without this unifying and energizing force; they were slower to organize than their colleagues in the east.[13]

By the early 1820s, however, the growing danger presented by sectarian practitioners had begun to threaten the traditionally trained physicians in central as well as coastal Georgia, in the small towns as well as the cities. It was an enemy all feared. Regardless of whether the sectarian physicians went under the name Thomsonianism, homopathy, or botanic medicine, they struck at the very heart of accepted medical philosophy. It was against this enemy that the physicians of central Georgia were finally able to unite.

The Central Medical Society

The spark for a state-wide medical organization came from Augusta. Actually, Augusta may have had an unchartered medical organization as early as 1808, but it took the energy of one man and the threat of the sectarians to bring that organization to life.[14] In 1822, when the Augusta Medical Society was finally chartered, it had only nine members, but its size belied the energy of its founders who, for the most part, were the same men instrumental in founding the state's first medical college at Augusta. As with the Medical College, Milton Antony seemed to be the chief energizing force behind the organization.[15]

Once the society was chartered, Antony and his group began at once to lobby in Milledgeville for passage of a statewide licensing act. Of course, their real purpose was to exclude sectarian practitioners. Within three years, they were successful; in 1825, the Georgia legislature passed an Act establishing a Medical Board of Examiners. A second act was then passed forbidding anyone to practice medicine in Georgia without a license granted by the Board. The license could be obtained in one of three ways: by having practiced medicine in the state before 1825; by presenting a diploma or some other proof that one had graduated from a recognized or chartered medical school—at the time there were no chartered botanic schools in Georgia; or by passing the Board's examination.[16]

The Board, composed of 20 physicians representing every region of Georgia, first met in December, 1825. It immediately, and to no one's surprise, elected Milton Antony its president. Also at the first meeting, the Board created the Central Medical Society to which Antony was also named chairman *pro tempore*. The society was apparently designed as a statewide medical society since its membership included physicians from Savannah to Athens, and from Augusta to Monticello. In reality, however, the Central Medical Society was never recognized as more than a regional group by the Georgia Medical Society which dominated the heavily populated eastern part of the state. Indeed, that that Society was able to lay claim to the title of a statewide organization at all depended largely on its ability to dominate the State Board of Medical Examiners. Its success in dominating this group depended largely on the outcome of the growing struggle between regular and irregular medicine for the support of the legislature.[17]

Victory, Defeat, and Compromise

This struggle had not ended in 1825 with the passage of the licensing act; the Act's proponents had won only the first battle, not the war. Indeed, they won this early test of strength only because they struck before the state's sectarian physicians could marshall their forces and gain sufficient strength among local voters. The botanics had no intention of giving up the contest; the law of 1825 forbade them from practicing medicine in Georgia but not from lobbying for repeal of the act. By the early 1830s, the botanic movement was stronger than ever and as it grew in strength, the power of the Medical Board and the Central Medical Society declined. By 1832, the Central Medical Society had become little more than a local organiation encompassing the physicians of Milledgeville and a few surrounding counties. The Board of Medical Examiners continued, but its power to enforce its will throughout Georgia was also declining. Finally, in 1836, the legislature revoked the 1825 act and again left each individual free to decide who was and who was not a qualified physician. For a time, the dream of a statewide medical society also died. The Central Medical Society continued with its strength centered in the Medical College of Georgia and her graduates. The Georgia Medical Society remained the state's most prestigious and largest society. Not until 1849 would the state's physicians finally be able to unite in one statewide medical society, the Medical Association of Georgia.[18]

As for the Thomsonians, they disappeared after Thomson's death in 1843 but were succeeded by other similar philosophies such as homopathy, hydropathy, chrono-Thermolism, and many others. Indeed, the nineteenth century proved to be the golden age of sectarian medicine.

In Georgia the fight for control between sectarian and traditional medicine continued for most of the century. The Licensing Act of 1825, revoked in 1836, was repassed in 1839 and stayed on the books until 1881. However, it was rarely enforced. In fact, Georgia came to have its own Botanic Medical Col-

lege. In 1881, a third licensing act was passed which, in effect, created three boards of medical examiners, one for the traditional practitioners, one for the homopaths, and one for the so-called eclectic school which tried to combine botanic and traditional practices.[19] This seemed to pacify all groups for a time. Soon, however, discoveries in bacteriology and advances in surgical skills would give the formally trained practitioner the tools to defeat his sectarian rivals who survive today only in the patent medicine industry. ■

REFERENCES

1. Mettler, Cecelia C.: Georgia degreed physicians previous to 1830; *JMAG,* 28:43, Feb., 1939.
2. Boland, Frank K.: Historic Savannah; *JMAG,* 24:173, March, 1940.
3. Editors, *The Medical Repository,* II, 2d Hexoide, 209.
4. *Georgia Republican and State Intelligencer* (Savannah), Aug. 13, 1805, p.4.
5. Bassett, Victor H.: Pages from the history of the Georgia Medical Society; *JMAG,* 29:127, March, 1940.
6. *Savannah Republican,* Aug. 18, 1818, p. 3; Sept. 15, 1818, p. 3; Sept. 21, 1819, p. 3; Sept. 29, 1819, p. 3; Oct., 1819, p. 3; Oct. 13, 1810, p. 3; Oct. 27, 1818, p. 3; Nov. 3, 1819, p. 3.
7. Duffy, John: *Epidemics in Colonial America;* Baton Rouge, La., 1953, p. 33.
8. Thomson, Samuel: *New Guide to Health; or, Botanic Family Physician;* Boston, 1822, pp. 1-162. This first section of Thomson's work consists of a brief autobiography which serves as the source of most information on Thomson's early life.
9. Grandy, Luther B.: History of medicine and surgery in Georgia; *Va. Med. Monthly,* 22:588, March, 1895.
10. Grandy, pp. 587-590.
11. The Georgia Medical Society Papers, Georgia Historical Society, Savannah, Ga.
12. A System of Medical Ethics, adopted by the Georgia Medical Society on the Fourth Day of February, 1821 . . . Savannah, 1822, pp. 1-3.
13. *Ibid.*
14. Grandy, pp. 588-590.
15. Dawson, William C.: *Compilation of the Laws of the State of Georgia, Passed by the General Assembly, Since the Year 1819 to the Year 1820,* Milledgeville, 1831, p. 116.
16. McGahee, R. C.: Early medicine in Augusta; *JMAG,* 27:83, March, 1938.
17. Dawson, pp. 291-292.
18. Mettler, Cecelia C.: The Central Medical Society of Georgia; *GHQ,* 24:145, June, 1940.
19. Boland, Frank K.: History of the Medical Association of Georgia, 1849-1949; *JMAG,* 28:132, April, 1949.

SYMPOSIUM '77 PICKS THEME—THE HUMAN RESPONSE

The 12th annual Cobb County Symposium '77, scheduled for March 31 and April 1, has been planned under the theme, "The Human Response." Headlining the list of speakers is Dr. Loren Eiseley, literary naturalism and Benjamin Franklin Professor of Anthropology at the University of Pennsylvania.

The program is sponsored by the Cobb County Medical Society in cooperation with Kennesaw Junior College, the Cobb County Ministerial Association and the Cobb County Bar Association. The program will be held at Kennesaw Junior College, except the closing session with Dr. Eiseley in the Ballroom of Hyatt Regency Hotel in Atlanta.

Speaking first, Thursday evening, March 31, is Dr. William Muehl, professor of practical theology at Yale Divinity School and member of the Michigan Bar Association. His topic is "The Human Response to the Abuses of Love."

Friday morning Steven F. Brena, M.D., director of the Emory Pain Clinic and author of the book, *Pain and Religion,* will speak on "The Human Response to Pain." He will be followed by Robert Shaw, conductor of the Atlanta Symphony Orchestra reviewing "The Human Response to the Arts" and Dr. Granger E. Westberg, theologian and professor at Abraham Lincoln School of Medicine in Chicago. His is the author of "Good Grief," and will speak on "The Human Response to Grief and Loss."

A panel discussion will be held with the three Friday speakers, lunch will follow, then symposium participants can meet with the speakers in small groups.

Friday evening Dr. Eiseley will close Symposium '77 with the dinner session at the Hyatt Regency. He is the author of 12 books including *The Immense Journey* and *Darwin's Century.*



Clockwise: Anthropologist Richard Leakey, Steven Brena, M.D., Loren Eiseley, Ph.D., Granger Westberg, Ph.D., William Muehl, Ph.D., Conductor Robert Shaw.

For information and registration, call or write Symposium '77, Kennesaw Junior College, Marietta, Ga. 30061; (404) 422-8770.

Of special interest before hearing Dr. Eiseley is a program to be held Saturday, March 26, 10 am-4 pm, at the World Congress Center in Atlanta. "Violence: Is It Innate in Man?" will feature Anthropologist Richard Leakey of Kenya, Africa, one of the world's foremost authorities on early man.

A "Snow-Storm" Ultrasound Pattern in the Uterus

C. MURPHY, M.D. *and* R. BARLOW, M.D., *Atlanta**

DR. RICHARD BARLOW: The patient is a 49-year-old female who presented to the OB Clinic with a two to three month history of abdominal swelling. She had a positive pregnancy test and on physical exam had a 24-26 weeks size pelvic and abdominal mass that was inseparable from the uterus. The mass was described as "boggy" or soft. No fetal heart tones were discernable. Here are the abdominal films which were made at that time. Dr. Murphy, will you discuss this case?

Dr. Christine Murphy: The abdominal radiographs reveal a homogeneous increased density in the pelvis and lower abdomen. The bowel gas appears to be displaced upward and draped over the mass. No calcifications or fat densities are seen within the mass. Also, no fetal parts are identifiable.

Dr. J. L. Clements: What lesion were you considering when you looked for calcifications and fat densities?

Dr. Murphy: A dermoid or teratoma may present as a large pelvic and abdominal mass. They often contain calcifications resembling attempts at bone or tooth formation, and may contain fat. This fat can at times be seen layering out on upright films.

Dr. H. S. Weens: In light of the patient's clinical history, what would be your next approach or procedure in diagnosis?

Dr. Murphy: As the patient had a positive pregnancy test, the least invasive procedure that might establish a diagnosis would be ultrasonography. This could determine if the mass is uterine or adjacent to the uterus; and whether a gestational sac or fetus is present. Ultrasound can also determine if the mass is solid or cystic.

Dr. Barlow: Abdominal ultrasound was performed the following day. Here are representative sections (Figure 1).

Dr. Murphy: Longitudinal and cross sections of the body through the area of the mass reveal a relatively homogeneous stippled or "snow-storm" pattern highly suggestive of a molar pregnancy. A persistant clear area or area with fluid characteristics is seen anteriorly on all sections. A separate uterus is not identifiable and again no fetal parts are seen.

Dr. Clements: On the basis of this study, what is your diagnosis?



FIGURE 1

Longitudinal B-mode ultrasound scan in the midline. The "U" indicates the umbilicus; the "S" indicates the symphysis. The arrows indicate the anterior extent of a mass demonstrating multiple amorphous echoes—the so-called "snow-storm" pattern of hydatidiform mole.

* From the Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30303. Conference material edited by Drs. J. L. Clements and H. S. Weems.



FIGURE 2

Amniogram demonstrating multiple filling defects representing the cystic chorionic villi of hydatidiform mole.

Dr. Murphy: With the clinical history of a rapidly growing soft mass and positive pregnancy test associated with the ultrasound findings, my first choice would be a molar pregnancy. Another consideration would be a large tumor with solid and cystic components arising from the pelvic organs. This could be associated with an early intrauterine pregnancy that has escaped detection on the ultrasound. Large fibroids can give this picture, also they may become cystic during pregnancy. Another possibility would be a cystic teratoma.

Dr. Barlow: As the surgical approach is evacuation of uterine contents from below with a mole and transabdominally for the other lesions, an amniography was performed to confirm the diagnosis. Here are the selected films (Figure 2).

Dr. Murphy: For amniography, a spinal needle is inserted in the abdomen in the midline below the umbilicus and 5-10 cc of Renografin 60 is injected under fluoroscopic observation.

These spot films reveal contrast surrounding multiple small cystic structures diagnostic of the cystic chorionic villi of the hydatidiform mole.

Dr. Barlow: Evacuation of the uterine contents revealed a benign mole. There was associated hemorrhage which was felt to account for the echo-free areas on the ultrasound.

Discussion

For rapid and safe evaluation of abdominal and pelvic pathology in the pregnant female, ultrasonography should often be the modality of first choice. In evaluating for a possible molar pregnancy, ultrasonography has a very high diagnostic accuracy.

As in this case, hydatidiform moles typically reveal a formless "snow-storm" pattern on ultrasound with absence of fetal parts. A tangential section through the placenta may also give this appearance, however by taking multiple sections transversely and longitudinally through the body, this can easily be differentiated. Other entities which rarely may also give a similar picture include a missed abortion; an early or ectopic pregnancy; multiple early gestations; ovarian tumors; and degenerating leiomyomas or sarcomas of the uterus. ■

REFERENCES

1. Grossman, Michael: "Diffuse Formless Intrauterine Echoes"; *Seminars in Roentgenology,* Vol. 10, No. 4 (Oct.), 1975.
2. King, Donald: *Diagnostic Ultrasound;* St. Louis, The C. V. Mosby Co., 1974, pp. 193-194.
3. Kobayashi, Mitsunao: *Illustrated Manual of Ultrasonography in Obstetrics and Gynecology;* Philadelphia, J. B. Lippincott Co., 1974, pp. 178-203.

ASK MEDICARE . . .

Q: In most cases my claims are processed promptly. Sometimes, however, the checks are delayed . . . how come?

A: Lack of definite documentation on physicians' bills or on Request for Payment forms continues to be one of the greatest obstacles to prompt reimbursement of Medicare benefits. For example, in June, more than 5,000 claims required additional information in order to deal fairly with physicians and patients. Missing diagnoses and failure to itemize charges were the primary problems. A current issue of Prudential's Medicare Bulletin discusses a list of billing tips designed to reduce investigative phone calls and expedite payment.

Q: Although my fees certainly seem reasonable to me, Medicare's Explanation of Benefits often shows a difference between the submitted and allowed amounts.

A: There have been some misunderstandings about the term "reasonable charge" as described in the Medicare handbook. "Allowable amount" would be more explicit. SSA has set forth the following criteria for determing this figure: carriers must compare the physician's or supplier's customary fee for any given service with the 75th percentile of the range of charges for that service by physicians or suppliers of the same specialty within the area. Reimbursement must be based on the lower of these two amounts. The above-described figures are those of the previous calendar year and are updated annually at the beginning of each new fiscal year.

editorials
editorials
editorials

Politics and the AMA: What They Mean to You

IN THE FACE of a changing White House whose attitude toward our profession is ambiguous, we need unity as never before.

This means having an American Medical Association that is buttressed by unified membership. Only the AMA has the moxie, the expertise, and the experience to fight all our joint fights.

But in Washington's gimlet eyes, those qualities are diluted unless the AMA also has great numerical strength. And that's where you come in—you as individuals and as component societies.

Calling for unity against our common dangers is not a case of the boy crying "Wolf!" against make-believe wolves. The wolves are all too real. Consider some of them.

Regardless of a distaste for specifics, President-elect Carter has made it pretty clear that he will take an activist stance on health issues. The sociologically oriented freshmen of the last Congress will be back in force, and without fear of Presidential vetoes. You can expect moves for a heavily federalized, blow-by-blow form of National Health Insurance, with the Social Security Administration as its mismanager.

You can expect a drive for an even more repressive and arbitrary Health Planning Act (which comes up for renewal in 1977)—provided this act survives the joint lawsuit of the AMA and the State of North Carolina. The drive could include an amendment mandating all states to regulate health-care rates.

You can expect a move to expand Medicare-Medicaid benefits without increasing the cost. How would this sleight of hand be achieved? By greater reliance on allied health professionals.

You can expect intensified efforts to federalize the standards for medical licensure and tilt the pharmaceutical wheel toward generic simulations.

How effectively can the AMA resist all the threats?

Well, ponder what it achieved in the last Congress. As the objective *National Journal* stated, the AMA got the fangs taken out of health-manpower legislation. It got the PSRO law amended to permit statewide PSROs and affirm the limitation of review to samples. It got the HMO Act amended, so that individual employees (including union members) can decide on their own whether to enroll in an HMO. It helped hold the line on NHI.

The AMA did all of this while forging ahead on many other programs—such as honing the skills of component societies in negotiating with third parties; expanding its program of continuing education; pressing its suit against the MAC rules; pressing for action against the Medicaid fraud that some politicians are using to smear our whole profession; establishing a firm (AMACO) to reinsure physician-controlled professional-liability programs.

The AMA's achievements have been your advantages. Its future and yours are one and inseparable. Your membership in the AMA is a paving block in your only sure road to a good tomorrow.

Prepared by the AMA Public Affairs Division.

Reflections on the MAG Scientific Assembly, 1976

IN 1975 THE MAG initiated the "new era" of its annual Scientific Assemblies. The format of having the various specialty societies develop their own programs with financial and administrative help from MAG proved successful. There were problems, to be sure. Not every society was represented. The logistics of space and registration were not smooth. Many felt scientific exhibits were needed. Attendance was not as good as hoped. But above all the quality of the program was excellent, stimulating enthusiasm for 1976.

We have just completed the 1976 Scientific Assembly. Attendance was up—to over 500—and facilities were better. We were treated to a timely and thought-provoking Abner Calhoun Lecture on medical manpower by Jack Myers, M.D., currently President of the American College of Physicians. Returns from the evaluation questionnaires were generally favorable, indicating the programs were relevant to the practices of those attending.

Again, the overriding aspect of this assembly was the excellent quality of the meetings. The participating specialty societies and their program chairmen are to be commended for developing and maintaining such a standard of excellence. Their cooperation and enthusiasm were certainly appreciated by all of the Planning Committee and MAG staff working with the Assembly.

There were some problems. Not as many specialty societies as we had hoped participated. Attendance, while up, was not as good as we would have liked. Several administrative problems still need solving. The very excellent wives' program was poorly attended.

This is *our* Scientific Assembly. The whole area of professional postgraduate education is becoming increasingly important as we are being asked to give an account of our "keeping up." We welcome new ideas and innovations in the development of future programs. We need more participation among the specialty societies and greater attendance at the meeting. The challenge to maintain the standard of excellence is directed towards all of us. I know it will be maintained.

James K. Van Buren, M.D.
Chairman
Committee on 1976 Scientific Assembly

Report on the 1976 Scientific Assembly

THE 1976 SCIENTIFIC ASSEMBLY was held November 19-20 at the Omni International Hotel in Atlanta with 528 people in attendance. This number was up 125 from last year's.

The purpose of the Assembly is to provide a source of high quality continuing medical education to physicians and other health professionals and to serve as a forum for the state specialty societies to present their own scientific programs. This year, 15 specialty societies participated in programs which lasted anywhere from two hours to two days. Those participating were:



Dr. Frank Wilson, Jr. (L) presents award to Dr. Lynn Hyland for the best resident's paper presented to the Georgia Chapter of the American College af Surgeons.

American Association of Public Health Physicians, Ga. Chapter
Georgia Thoracic Society
American College of Chest Physicians, Ga. Chapter
American College of Physicians—Ga.
American College of Surgeons, Ga. Chapter
Atlanta Dermatological Association
Georgia Society of Dermatologists
Georgia Gastroenterologic Society
Georgia Neurological Association
Georgia Neurosurgical Society
Georgia Psychiatric Association
Georgia Radiological Society
Georgia Society of Nuclear Medicine
Georgia Society of Ophthalmology
Georgia Society of Plastic Surgeons

The most well attended program was on Internal Medicine, presented by the American College of Physicians—Georgia. Doctors Thorne S. Winter, III and Warren W. Davis are to be congratulated for a fine job of planning. There were 134 present to hear seven out-of-state guest speakers.

Dr. Alan L. Plummer did a good job of planning the program presented jointly by the Georgia Thoracic Society and the American College of Chest Physicians, Georgia Chapter. The Georgia Radiological Society, Georgia Gastroenterologic Society and American College of Surgeons, Georgia Chapter, combined to present a very successful program under the title of "The Biliary Tree."

On Friday, November 19, MAG sponsored a luncheon for all attending physicians and their spouses. The 1976 Abner W. Calhoun lecture was delivered at the luncheon by Dr. Jack D. Myers of the University of Pittsburgh School of Medicine, president of the American College of Physicians. His subject was "The Distribution of Training Opportunities in Graduate Medicine."

Surgical residents presented essays in competition before the Georgia Chapter of the American College of Surgeons. Dr. Lynn Hyland of the Georgia Baptist Medical Center was selected for presenting the best paper and received an award from the association. His subject was the evaluation of patients with potential venous thrombosis.

In addition to the medical professionals from all over the state, the Assembly had several special guests. A team from the AMA was present, surveying the various programs with an eye toward granting accreditation to MAG's continuing medical education program.

Comments from attendees indicate that the Assembly was quite successful. The 1977 meeting will also be held at the Omni International in Atlanta, with dates set for November 18-19.



Dr. Jack D. Myers (L) delivers the Calhoun lecture at MAG's luncheon. Seated with him are Drs. James K. Van Buren, chairman of the Assembly, and Carter Smith.

I've told this before

(Ed. note: A surgeon has his first experience with sodium pentothal in this story by J. Morgan Kellum, M.D. Others wishing to submit material for this page should contact the Journal of the Medical Association of Georgia *at 938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Caution Was the Watch Word

WHEN I WAS a senior medical student, I had a summer job in a small Mississippi town. The clinic was operated by two brothers in their sixties; one was a G.P.-surgeon, and the other, a G.P.-anesthetist.

Drop ether was used exclusively. Sodium Pentothal had just appeared on the market. The anesthetist continually nagged his brother for his permission to try out the new drug.

Finally, one day, the surgeon gave in. But he said, "Be damned careful with that stuff. We don't want to kill somebody with it!"

So, the next surgical patient was given Pentothal. The anesthetist was cautious, alright! The patient counted to 100, as he injected it, SLOWLY, and then began all over and counted to 175. The surgeon was getting so impatient, he was climbing the walls. Then the patient let out a big yawn and said, "Good-bye, Doc, bury me at Big Bethel!"

J. Morgan Kellum, M.D.
Thomaston, Georgia 30286

president's letter

Not a Game, Just Communicating



BY THIS TIME, any new resolutions for '77 will likely have been forgotten and, except for paying the bills, Christmas '76 is long history.

In going about the state this past year, the same old question of "what is MAG or AMA doing for me?" is asked. Quite naturally, it is usually a thought as one writes out that big check for his dues, for many most reluctantly.

It is intriguing how little is known of this organization by so many. In January, February and March I'm embarking on a little survey. For those who wish to identify themselves, I'll send back a 13 cent stamp each time upon receiving his answers. Let's not call it a game, but rather knowing who we are and communicating. O.K.? Here goes:

1. Have you ever been to the MAG office?
2. How many times a year do you come to Atlanta?
3. Do you live in the Metropolitan Atlanta area?
4. Did you call the MAG office in 1976?
5. What are your favorite two eating places in Atlanta?
6. What is your favorite eating place in Savannah?
7. Have you attended a scientific MAG program in the past two years?
8. Who is your MAG councilor?
9. Have you ever spoken or written to a Georgia legislator?
10. Who is Lola Brown?

Sincerely,

Fleming Jolley

Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Cardiopulmonary Resuscitation: The Challenge and How It Is Being Met

ROBERT P. CUNNINGHAM, M.D., *Atlanta**

IT HAS BEEN ESTIMATED that about one million persons in the United States experience acute myocardial infarction each year. More than 650,000 die annually of ischemic heart disease. About 350,000 of these deaths occur outside the hospital, usually within two hours after the onset of symptoms. Thus, sudden death from heart attack is the most important medical emergency today. It seems probable that a large number of these deaths can be prevented by prompt, appropriate treatment. In addition, many victims who die as a result of such accidental causes as drowning, electrocution, suffocation, drug intoxication, or automobile accidents could be saved by the prompt and proper application of cardiopulmonary resuscitation (CPR) and emergency cardiac care. This can best be assured by the victim's entry into an organized and effective system of emergency cardiac care.

Emergency cardiac care (ECC) is an integral part of a total, community-wide comprehensive system of emergency medical services (EMS) and should be integrated into the total system response capability for all types of life-threatening situations.

Training Program Evolves

In May 1966, the National Academy of Sciences-National Research Council sponsored a conference on CPR that recommended the training of medical, allied health, and professional paramedical personnel in CPR according to the standards of the American Heart Association. Those recommendations resulted in widespread acceptance of CPR and training in the technique. In 1973 the American Heart Association and the NAS-NR Council cosponsored a National Conference on Standards for CPR and Emergency Cardiac Care. This conference was conducted because of the changes that had occurred during the intervening years. It became apparent that a broad national program of life support measures was required to bring the benefits of CPR and emergency cardiac care to everyone. It is felt that this can be accomplished only by intensive programs to assure adequate training of all medical and paramedical personnel as well as large segments of the public in basic life support measures.

Basic Life Support is an emergency first aid procedure that consists of the recognition of airway obstruction, respiratory arrest and cardiac arrest, and the proper application of CPR which includes opening and maintaining a patent airway, providing artificial ventilation plus artificial circulation by means of external

* Chairman, CPR Task Force of the Georgia Heart Association. Dr. Cunningham's address is P.O. Box 2211, 614 Hurt Bldg., Atlanta, Ga. 30301.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

cardiac compression. Performance of CPR is therefore a psychomotor skill requiring from four to six hours of lecture, demonstration, manikin practice and then cognitive as well as performance testing. Every effort is made to assist each student achieve near perfection in performance in order that he may hopefully translate these efforts later in a successful resuscitation of a patient. The National Conference recommended that all physicians and nurses should be competent in all phases of basic CPR and that this be a requirement for annual staff appointment.

CPR programs are offered beginning with specific need groups such as policemen, firemen, lifeguards, rescue workers, families of cardiac patients, and then expanded to the general public including students in the eighth grade and above. The American National Red Cross, medical organizations, and other agencies concerned with lifesaving will participate in these programs which must also guarantee the availability and accessibility of an emergency care system for effective treatment of patients at the scene and during transportation by well trained emergency medical technicians and rescue personnel. Then personnel at all levels of cardiac care must be taught Advanced Life Support which is basic life support (CPR) plus use of adjunctive equipment, intravenous fluids and drugs, defibrillation, control of arrhythmias, etc.

Taught in Pyramid System

The pyramid system is utilized in teaching CPR. At the state level, the affiliate faculty instructs the instructor trainer, who in turn instructs the instructor, who then teaches basic CPR. Certification of an instructor requires successful completion of a two day course and then being monitored during the subsequent teaching of a course. The purpose of certification is to maintain adherence to uniform national standards established or recognized by the American Heart Association and will be accomplished by the use of written and performance examinations. Periodic rccertification will be required.

Georgia Heart Association's role is to train, certify and recertify instructor trainers on a continuing basis and to maintain American Heart Association standards. Through the efforts of CPR committees of county heart units, basic CPR programs will be conducted in local communities. From 1969 through 1974, under the auspices of Georgia Heart Association, over 6,000 persons were trained as instructors and over 50,000 as basic rescuers under the old standards. Since 1975, training under the 1973 conference standards has produced over 200 instructor trainers, over 700 instructors and several thousand persons trained in Basic Life Support. Twenty affiliate faculty members have conducted 12 two day instructor trainer courses in Atlanta (four), Athens, Augusta, Savannah, Valdosta, Albany, Columbus, Macon and Rome. A new teaching tool has been utilized in teaching instructors—the *Recording* Resusci Anne. The long used and invaluable Resusci Anne simulates quite well the performance of mouth to mouth ventilation and external cardiac compression. It is, however, somewhat difficult to assess the ventilatory volumes and the depth of sternal compressions. The *Recording* Resusci Anne produces a tape which records all components of CPR and permits the instructor and student to visualize, immediately following performance, the exact ventilation volume, rate and depth of sternal compressions and correctness of hand position.

Advanced Life Support (ALS) consists of the following: (1) basic CPR; (2) use of adjunctive equipment and special techniques, such as endotracheal intubation; (3) cardiac monitoring for dysrhythmia recognition and control; (4) defibrillating; (5) establishing and maintaining an intravenous infusion, (6) employing definitive therapy including drug administration (a) to correct acidosis and (b) to aid in establishing and maintaining an effective cardiac rhythm and circulation; and (7) stabilization of the patient's condition.

Courses Set for Atlanta

Georgia Heart Association sent six physicians to be trained and certified by the American Heart National faculty in Advanced Life Support. In June 1976, they conducted the first Advanced Life Support Course to train additional faculty. The second course was then taught by these 18 physicians in August and was monitored by a member of the National Faculty. Twenty-nine additional physicians successfully completed this two and one-half day course. The third ALS course will be held in Atlanta at the end of January, 1977 and a fourth is tentatively planned for June, 1977. Instructors trained at these courses have already begun to teach the basic ALS course which is termed a *provider* course. This course is very similar to the instructor course and can be conducted in a single one and one-half to two day period or can be divided into multiple short sessions presented over variable periods. It is planned that only physicians will be certified as affiliate faculty in ALS and initially also at the instructor level. In the future, other professionals will be certified as instructors and basic provider courses will be taught to all professional and paraprofessional personnel at all levels of cardiac care. In ALS, a person taking the provider course must first be certified in basic CPR and one taking the instructor course must be first certified as an instructor in basic CPR.

It is evident therefore, that the technique of cardiopulmonary resuscitation must be taught to thousands of people both professional and lay so that victims of sudden "clinical" death may be resuscitated before "biologic" death insues. Georgia Heart Association's CPR Task Force is responsible for training instructors for both Basic Life Support and Advance Life Support and for the maintenance of American Heart Association standards.

For additional information, contact your local county heart unit CPR committee or the Georgia Heart Association. ■

Opportunities for Continuing Medical Education

OPHTHALMOLOGY AND PULMONARY DISEASES

Feb. 1, 1977
Ft. Oglethorpe
Sponsored by the Hutcheson Memorial Tri-County Hospital, and Medical College of Georgia
Contact: Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Ft. Oglethorpe, Ga. 30742

THE IMPAIRED PHYSICIAN: ANSWERING THE CHALLENGE

Feb. 4-6, 1977
Hyatt Regency Hotel, Atlanta
Sponsored by the AMA and the MAG
Contact: Dept. of Mental Health, AMA, 535 N. Dearborn St., Chicago, Ill. 60610

WORKSHOP ON ESTABLISHING YOURSELF IN MEDICAL PRACTICE

Feb. 22-23, 1977
Airport Holiday Inn, Columbus
Sponsored by AMA and MAG
Registration: $95, medical association members, $125, non-members
Contact: Stephen L. Daniel, Ph.D., MAG Headquarters, 938 Peachtree St., NE, Atlanta, Ga. 30309; (404) 876-7535.

1977 ATLANTA GRADUATE MEDICAL ASSEMBLY

March 14-16, 1977
Omni International Hotel, Atlanta
Sponsored by The Medical Association of Atlanta
Contact: Medical Assn. of Atlanta, 875 West Peachtree St., Atlanta, Ga., 30309; (404) 881-6128; 881-3862.

ENDOCRINE CAUSES OF MENSTRUAL DISORDERS

March 16-18, 1977
Hilton Inn, Memphis, Tennessee
Sponsored by The University of Tennessee Center for the Health Sciences College of Medicine
Approved for 20 elective hours by AAFP and 30 cognates by Amer. College of OB/GYN.
Contact: Div. of Continuing Education, UTCHS, 800 Madison Ave., Memphis, Tenn. 38163; (901) 528-5547.

40th ANNUAL NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

March 28-31, 1977
The Fairmont, New Orleans, La.
Registration: $125, military, $62.50, complimentary to students, residents, interns and fellows
Contact: The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Ave., New Orleans, La. 70112; (504) 525-9930.

legal page
legal page
legal page

The California Natural Death Act—Some Help With Antidysthanasia

RICHARD H. VINCENT, *Atlanta**

On September 30, 1976, Governor Brown of California approved for that state a unique piece of legislation known as the Natural Death Act (the "Act"). The Act establishes a procedure whereby a person may provide in advance for the withholding or withdrawal of medical care in the event he should suffer a terminal illness or mortal injury. Similar legislation may appear in other states desiring to eliminate some of the uncertainties facing a doctor with a terminal patient.

Present Georgia law in this area reflects the general uncertainty existing in most states. A Georgia physician is required to bring to the exercise of his profession that degree of care and skill which, under similar conditions and like surrounding circumstances, is ordinarily employed by the profession generally. Where a terminal patient is involved, such a broad statement of responsibility offers no real guidance to the physician. Can there ever be a situation where the withholding or withdrawal of treatment could reflect an acceptable degree of care and skill on the part of the doctor? Only in one minor respect does Georgia law lend any certainty in this situation: the Georgia Determination of Death Act permits a person to be pronounced dead when he has suffered an irreversible cessation of brain function. Persons acting in good faith in accordance with the Determination of Death Act are protected from civil or criminal liability for failure to administer further treatment.

Right to Refuse Treatment

Another relevant legal proposition concerns the qualified right of a competent adult patient to refuse medical treatment. In some states, the patient's right to refuse treatment has been upheld on the theory that the administration of treatment against the patient's wishes would constitute a criminal battery, would abridge the patient's constitutional right to the free exercise of his religious beliefs, or would violate his right of privacy, or a "right to be left alone." Most states, however, have gone to considerable lengths to limit and qualify a patient's right to refuse medical treatment. For example, courts have universally held that a parent has no right, based on his religious beliefs or any other grounds, to deny necessary medical treatment to his child. With adults, the courts have generally tended to order treatment wherever they could find some factual basis for doing so (such as the fact that the patient was pregnant, the fact that the patient had voluntarily submitted to care in the first place, etc.).

The Georgia legislature also has tried to ease the physician's dilemma in this situation by enacting the Georgia Medical Consent Law under which patient consent is implied in situations where an "emergency" exists (as defined in that

* Prepared at the request of The Medical Association of Georgia. Mr. Vincent is a partner in the firm of Powell, Goldstein, Frazer and Murphy, general counsel to the Association, Eleventh Floor, C & S National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

statute). Even the Medical Consent Law, however, preserves a great deal of uncertainty by concluding with a provision that "nothing contained herein shall be construed to abridge any right of a person 18 years of age or over to refuse to consent to medical or surgical treatment as to his own person."

The physician's dilemma is even more troublesome where the patient is terminal and is already, or is likely to become, *non compos mentis*. One example of the situation where a terminal patient is already incompetent is the Karen Quinlan case; she was an incompetent and had been unable to make any decisions on her own behalf since the onset of her illness. (In the Quinlan situation, the New Jersey Supreme Court has established four criteria for discontinuing life support measures for incompetent individuals: (1) attending physicians must conclude that there is no reasonable possibility that the patient will emerge into a cognitive, sapient state; (2) the patient's family and guardian must concur in the decision; (3) once the attending physician and the family have reached agreement, they must consult with the hospital's ethics committee or a similar committee of the institution in which the individual is a patient; and (4) the committee must agree with the decision reached by the attending physician.)

Following Patient's Directive

The remaining situation—in which the terminal patient is still competent—is where the California Natural Death Act applies. The Act expressly authorizes the withholding or withdrawal of "life sustaining procedures" from adult patients afflicted with a "terminal condition" where the patient has executed a directive in a specified form and manner. A directive is generally effective for five years from the date of execution unless sooner revoked in a specified manner.

Under the protection of the Act, physicians and licensed health professionals acting under the direction of a physician are relieved from civil liability, criminal prosecution or charges of unprofessional conduct for withholding or withdrawing life sustaining procedures in accordance with the provisions of the Act.

"Life sustaining procedure" under the Act means "any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. Life sustaining procedure shall not include the administration of medication or the performance of any medical procedure deemed as necessary to alleviate pain." A "qualified patient" is a "patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient." "Terminal condition" means "an incurable condition caused by injury, disease, or illness, which, regardless of the application of life sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life sustaining procedures serve only to postpone the moment of death of the patient."

Several Safeguards

The Act contains a number of substantive and procedural safeguards. For example, the directive itself may not be validly executed until 14 days after the patient has been diagnosed as having a terminal condition by a doctor whose name and address must be specified in the directive itself. The directive is automatically void during the course of any pregnancy of the patient. Special safeguards are provided for patients in skilled nursing facilities who may be insulated from a voluntary decision-making role by virtue of the custodial nature of their care.

Elaborate and detailed methods for revocation of a directive are also provided. A directive may be revoked at any time by the declarant without regard to his mental state or competency by any number of methods including written revoca-

tion communicated to the attending physician, destruction of the directive by the declarant or someone in his presence acting under his direction, and verbal expression of the declarant of intent to revoke the directive communicated to the attending physician.

Criminal sanctions are also provided (a) for any person who willfully conceals, cancels, defaces, obliterates or damages the directive of another without the declarant's consent, or (b) for any person who, except where justified or excused by law, falsifies or forges the directive of another or willfully conceals or withholds personal knowledge of a revocation with the intent to cause a withholding or withdrawal of life sustaining procedures, contrary to the wishes of the declarant, and thereby causes such procedures to be withheld or withdrawn and death to thereby be hastened.

No Mercy Killing Approval

The Act expressly denies any implied approval of mercy killing: "Nothing in this chapter shall be construed to condone, authorize or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying. . . ."

Finally, the Act anticipates and purports to solve several problems anticipated as a result of the use of directives. For example, it provides that the withholding or withdrawal of life sustaining procedures pursuant to the Act shall not constitute a suicide nor impair or invalidate life insurance. Nor would the making of a directive pursuant to the Act restrict, inhibit or impair the sale, procurement or issuance of life insurance or modify existing life insurance. In addition, health insurance carriers could not require execution of a directive as a condition for being insured for, or receiving, health care services.

In summary, the California Natural Death Act provides for physicians and licensed health professionals in that state, as well as for most adult, cognitive, terminal patients, a safe procedure whereby antidysthanasia may be lawfully and reasonably employed. We may expect to see similar or even broader legislation enacted in other states in the coming years. In fact, at least one writer has already suggested extending application of the Act beyond terminal patients to those who may wish to decline treatment because they will be paraplegics or otherwise seriously handicapped—or even because they cannot afford treatment. ■

CONFERENCE ON IMPAIRED PHYSICIANS SCHEDULED

The Second Annual Conference on The Impaired Physician, sponsored by AMA and MAG, will be held February 4 through 6 at the Hyatt Regency Hotel in Atlanta. Among the speakers will be the chairman of MAG's program on Disabled Doctors, G. Douglas Talbott, M.D. Others on the program are Herbert Raskin, M.D., former chairman of the AMA's Committee on Alcoholism and Drug Dependence, Stanley Gitlow, M.D., clinical professor of medicine at Mount Sinai School of Medicine and Charles Whitfield, M.D., director of the Alcoholism Education Project of Southern Illinois University.

Major theme of the seminar will be successful programs and various treatment techniques used to help the physician-patient. The meeting will focus on physicians suffering from emotional, psychological or pathological conditions that may impair their judgment and skill. Workshop sessions will be held on AMA's Model Act and other legislative support mechanisms, the physician and his family as well as the legal, economic and educational aspects of the program. To date, more than 25 states have enacted legislation dealing with the disabled doctor.

The AMA's Model Act is preventive rather than punitive and establishes the state medical society as an agent of the state licensing body in this particular problem area. If more informal procedures fail, the legislation provides for restriction, suspension or revocation of a practitioner's license for reasons arising out of physical and mental illness.

NEW MEMBERS

Anton, Manuel P., DeKalb—Act—P
Dekalb Health Dept., 440 Winn Way, Decatur 30030

Berenson, Joel E., MAA—Act—R
Ga. Baptist Hosp., 300 Blvd., NE, Atlanta 30312

Brown, Ruth C., MAA—A—Pd
4770 N. Peachtree Rd., Atlanta 30341

Grant, Alfred A., Bibb—Act—P
1900 Randolph Rd., Suite 900, Charlotte, N.C. 28207

Griffin, Howard A., Jr., Ware—Act—R
P.O. Box 938, Waycross 31501

Ho, Chih-Ta, Sumter—Act—Pd
317 West Lamar St., Americus 31709

Johnston, Jack H., Hall—Act
96 Memorial Dr., Dahlonega 30533

Levine, Raphel S., DeKalb—Act—I
3648 Chamblee-Tucker Rd., Atlanta 30341

Levy, Arthur J., MAA—Act—TS
272 Blvd. NE, Atlanta 30312

Lewis, Norris S., Thomas Area—Act
907 N. Culpeper St., Quitman 31643

Lowe, James T., Jr., Bibb—Act—Oto
380 Hospital Dr., Suite 370, Macon 31201

Manfredi, John A., DeKalb—Act—On
2054-E Lawrenceville Hwy., Decatur 30033

Melich, Arthur, Cobb—Act—I
1680 Mulkey Rd., Suite E, Austell 30001

Nutt, Richard L., Colquitt—Act—Anes
709 S. Main Street, Suite C, Moultrie 31768

Rawlings, William, Jr., Washington—Act—I
522 Washington Ave., Sandersville 31002

Rosenbloom, Seymour J., Cobb—Act—I
1680 Mulkey Rd., Austell 30001

Shaker, Issam J., Bibb—Act—Su
726 First St., Macon 31201

Steller, Robert T., Colquitt—Act—Oph
720 S. Main St., Moultrie 31768

SOCIETIES

The Auxiliary of the **Georgia Medical Society** has been working hard to improve the quality of health education in local school curriculums by sponsoring health education seminars which have been attended by more than 800 students, principals and guidance counselors. The Auxiliary also has a committee, co-chaired by Mrs. Robert Carter and Mrs. John Northup, to establish an allied health careers club. The first meeting of the club is scheduled for this month.

Next month, the Auxiliary will give a dinner honoring all of Savannah's physicians who have been in practice for more than 50 years. Proceeds from the dinner will be donated to the AMA's Education and Research Foundation.

William E. Huger, a plastic surgeon who graduated from the Emory University School of Medicine and took specialty training at Duke University, was installed as president of the Medical Association of Atlanta. He succeeds L. Newton Turk. The president-elect, who will take office in 1978, is Charles E. Harrison, specialist in internal medicine.

The **Ware County Medical Society** elected a new slate of officers at its meeting last month. They are: O. C. Wynn, M.D., President; W. L. Pomeroy, Jr., M.D., Vice President; L. J. Duane, M.D., Secretary-Treasurer.

PERSONALS

Second District

H. Gordon Davis, Jr., of Sylvester was installed as president of the Georgia Academy of Family Physicians during its annual session held in Atlanta. Dr. Davis is a Fellow in The American Academy of Family Physicians and is a member of the State Advisory Board of Family Physicians.

Thomasville physician **Henry S. Pepin, Jr.** has been named a Fellow of the American Academy of Family Physicians.

Fourth District

Alan O. Feingold of Decatur has been elected a Fellow of the American College of Physicians.

John E. Skandalakis, M.D., Ph.D., professor of anatomy and assistant professor of surgery at Emory University's School of Medicine, has been honored with the new title of Chris Carlos Professor of Surgical Anatomy and Technique. The Chris Carlos Chair, the only one of its kind, was established by the Carlos Foundation Inc., in memory of a well-known Atlanta businessman. It consists of $50,000 plus a projected $30,000 a year for 10 years.

Fifth District

The prestigious Aven Cup Award for 1976 has been given to **Robert P. Cunningham,** general medical director for Southern Bell. The award is presented annually to an outstanding Atlanta physician by the Medical Association of Atlanta. MAA officials noted Dr. Cunningham's outstanding services to medicine and to his community, which included education efforts to prevent drug abuse, work with children who have speech defects and work with the YMCA.

THE ASSOCIATION / Continued

Eighth District

The Georgia Rehabilitation Counseling Association recently presented its Meritorious Service Award to **William C. Retterbush,** a Valdosta surgeon. Dr. Retterbush was cited for his "diligent work in providing medical services to clients and helping them return to work."

Tenth District

Franklin E. Payne, Jr. has been named a Fellow of the American Academy of Family Physicians.

Manjit Singh has been elected a Fellow of The American College of Physicians.

DEATHS

J. Fred Adams

Montezuma physician J. Fred Adams, 79, died December 7 in a Montezuma nursing home. He had devoted over 50 years to the practice of medicine before his retirement in 1973.

Dr. Adams participated in the establishment of the first hospital to be operated in Macon County. Then he went on to build, equip, staff and operate for 38 years the Macon County Clinic, along with Dr. Tom Adams.

He went to Emory Medical School and did his internship at Grady Memorial Hospital in Atlanta and at the Middle Georgia Sanitarium in Macon. He was later a clinician at the Macon County Health Department and took an active part in efforts to bring progress to Montezuma and Macon County.

Survivors include his wife, the former Frances Oliver; two sons, Dr. James F. Adams, III, a radiologist in Columbia, South Carolina, and Dr. Dolph Adams, Duke University pathologist; three sisters.

E. Earle Lewis

E. Earle Lewis died in the Veterans Administration Hospital in Augusta November 30, following several years of illness. He was 46.

Born in Wilkes County, Dr. Lewis was a graduate of the University of Georgia and the Medical College of Georgia and served in the Medical Corps of the Army for two years. Since 1961, he had been associated with the Clark-Holder Clinic in LaGrange.

Survivors include his wife, Patricia; two daughters, Theresa Lewis and Betty Jane Lewis; three sons, George, John and Timothy; his father, George A. Lewis; five sisters.

Tracey William Middlebrooks

McDuffie County physician Tracey William Middlebrooks died November 12 in an Augusta hospital.

Dr. Middlebrooks was a graduate of Mercer University and Medical College of Georgia and had practiced medicine in Thomson since 1966.

He is survived by his wife, Mary H.; two daughters, Sally Middlebrooks and Mrs. Ralph Greene; one son, Dr. Tracey Middlebrooks, Jr.; two brothers.

A unique hospital specializing in treatment of...

ALCOHOLISM
DRUG ADDICTION



In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

Patient package inserts for almost all drugs, one of the major demands of the consumer movement, with their attending problems and concerns were discussed at a two-day symposium here recently. The session was sponsored by the AMA, the Drug Information Association, the Food and Drug Administration, and the Pharmaceutical Manufacturers Association.

The patient insert should not be confused with the package insert. Years ago, Congress approved the requirements for the package insert for prescription drugs, apparently in the mistaken belief much of this information would get to the patient. Most of it went to pharmacists; none was required to be given to patients.

There were hearings in the last Congress on legislation introduced in House and Senate aimed at providing patients, with certain exceptions, insert information on the prescription drugs they receive.

FDA Commissioner Alexander Schmidt, M.D., told the symposium the consumer has a right to know about the medicine he is taking. "There is increasing evidence that a high proportion of Americans either do not understand the prescription instructions or do not follow them," Dr. Schmidt said. He contended there is a lack of effective communication often between physician and patient on drug information.

The information supplied patients must not be as detailed as the warnings required in advertising. This would be "an invitation to hypochondria," said Dr. Schmidt. Rather, the information should be in plain English, factual, and explain why the drug is being taken, major side-effects to watch out for, and when to report reactions to the physician.

William Barclay, M.D., AMA Group Vice President for Scientific Publications, said carefully prepared information about selected drugs is desirable and could be of service to patients, physicians, and pharmacists. However, Dr. Barclay cautioned that there is a clear danger that the disclosure could be so alarming as to discourage use of drugs that are vitally needed.

One of the major questions to be answered is how the insert would be distributed. "Obviously, the physician would rather not have the responsibility of stocking in his office perhaps thousands of brochures," he said.

Of even greater importance, is the liability and other factors involved when physicians in certain cases for the sake of their patients either want no insert provided or want to suggest doses or other information that might run counter to the insert's material.

Dr. Barclay noted that labelling has had little effect on cigarette smoking. He also noted that one of the most powerful drugs available with all sorts of adverse reactions and addiction potential—alcohol—would not be covered by the patient insert.

John Adams, Ph.D., Vice President of the PMA, said non-prescription drugs contain far more patient informational material than the stronger prescription drugs. However, the patient package insert could cause severe strain on the physician-patient relationship, he said. "An adequate explanation of the risks and benefits might be impossible in a brief description."

Joseph Onek, Counsel for the Center for Law and Social Policy, said physicians don't have the time to tell their patients all they need to know about drugs. Patients forget anyway. He suggested that a priority list be made up for the inserts, starting with all drugs used in pregnancy, then tranquilizers and barbiturates.

Social Security Records

The Social Security Administration is asking the public for help on how much information, including medical data, should be disclosed from Social Security records. "Social Security needs to change its regulation to make it conform with the Privacy Act, the Freedom of Information Act, and the new government in the Sunshine Act," a spokesman said.

"An important issue underlying these laws is the basic conflict between the public's right to know and the right of privacy of the people whose records are kept by Social Security," SSA Chief James Cardwell said. "We will need to resolve that conflict in our regulation, and we want the public's help."

Social Security said the revised regulation must address the basic information about an individual collected for purposes of administering the Social Security Act vs. interchange of such information with state or federal agencies to further efficient administration of other benefit programs, or to meet other governmental needs —a further concern is the public's right to know.

What personal information (including the Social Security number) should be disclosed by SSA without the consent of the individual in the following situations:

a. for entitlement or potential entitlement to other local/state/federal benefits or service;

b. for investigative or prosecution purposes.

Among other questions posed were, whether there should be limitations on disclosure of medical information to third parties and special procedures for disclosing medical information to the subject individual, and to make public fees paid to individual physicians, incorporated individual physicians, and other providers of medical services.

That medicine has had little to do with the improvement in mankind's health over the past several hundred years was the attention getting gist of the opening address theme of the annual meeting of the Institute of Medicine here.

There was some sharp disagreement with the speech by Thomas McKeown, M.D., Professor of Medicine at

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

the University of Birmingham, England, but Dr. McKeown insisted that "human health is determined mainly by way of life," not medical advances.

According to Dr. McKeown, the decline of mortality and growth of population started at the end of the 1600s, when farmers began a more scientific and diligent approach to producing crops. "This increase in food supplies between the end of the 17th century and the mid-1800s coincided with a substantial reduction of mortality from infectious diseases—and, it is suggested, was the main reason for it."

Powerfully supporting this progress was improved hygiene affecting the quality of food and water in the late 1800s, Dr. McKeown said. "The contribution of immunization and therapy has been recent and, over the whole period, relatively small."

The English physician said "that what is true for other living organisms is also true for man. Namely that health depends essentially on control of environmental influences, including those, which by his own behavior, the individual makes for himself."

Some institute members contended that Dr. McKeown was shortchanging the effect that immunizations and the post-1935 development of antibiotics, etc., have had on health. The speaker conceded that these have had a significant impact, but he said that in viewing huge population masses the new treatments do not loom large statistically in comparison with the general improvements in living conditions.

An analysis of the current burden of various illnesses in the United States based on use of medical services and facilities, loss of life and work time, was presented by Dorothy P. Rice, Director of the National Center for Health Statistics.

The rank order of categories of disease according to burden were: mental illness and handicap, respiratory diseases, ischaemic heart disease, bone and joint disease, accidents and suicide, and neoplasms.

The annual meeting concentrated on the state of treatment of schizophrenia, hypertension, and smoking and disease.

Airplane Pilot Examinations

"Airplane pilots need stricter physical examinations because medically unfit airmen continue to endanger themselves and the public," claims the General Accounting Office (GAO) in a report to Congress.

Most of the criticism was directed at private pilot screening but the GAO said that even commercial pilot tests are often less thorough than those for military pilots, air traffic controllers, and foreign civilian pilots.

Better medical examination requirements would be especially helpful in singling out pilots with heart trouble, alcoholism and high blood pressure, the GAO said.

The report suggested there are some 23,000 private pilots "who may represent potential safety problems, including about 12,500 with records of driving (autos) while intoxicated and 200 with physical disabilities which prevent them from driving an automobile," said the GAO.

The GAO, an investigative agency for Congress, proposed that the Federal Aviation Administration be allowed to review data of the National Highway Administration on withdrawal or denial of drivers' licenses for pilots.

Most scheduled U. S. airlines have tougher medical checks than required by federal law, but there is no requirement that the airlines notify the government when pilots with FAA medical certificates flunk their airline physicals, according to the GAO.

The GAO report and the recent publication of several books questioning airline safety and pilot reliability may lead to Congressional hearings in 1977.

Decrease in Hospital Beds

A National Academy of Sciences panel has called for a 10 per cent decrease in the ratio of hospital beds to population, claiming that a surplus of short-term, general care beds is contributing to higher medical costs. The panel said a national health planning goal should be to reduce the present ratio of 4.4 beds per 1,000 persons to 4.0 by 1981. This would be accomplished by curtailing hospital construction and closing down some existing hospital facilities.

Panel member John D. Thompson, of Yale University, estimates that about 50,000 hospital beds which are now either in use or slated for construction would have to be eliminated. He and the panel stressed the need for waiting periods for elective surgery as a way to increase hospital efficiency and occupancy rates.

The report sponsored by the Academy's Institute of Medicine also recommends shifting from the present system of retrospective cost reimbursement to a prospective rate-setting system. The report states the present third-party system "virtually guarantees the widespread development of excess bed capacity and encourages unnecessary and inappropriate treatment."

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Menieres Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

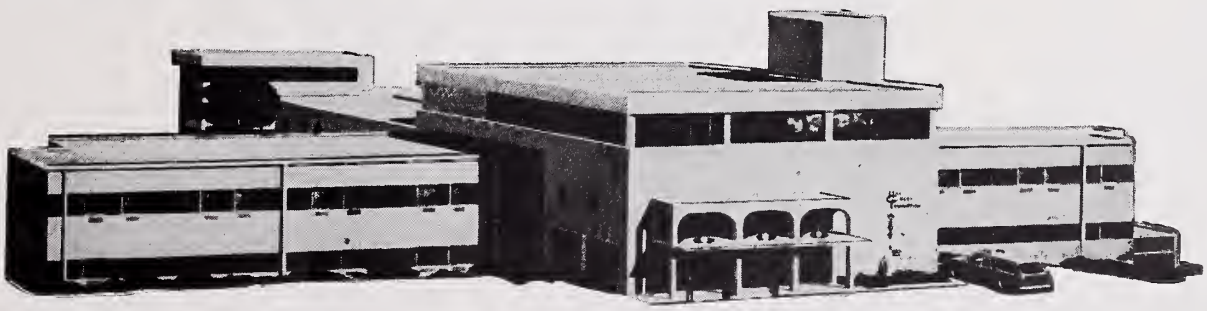
HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

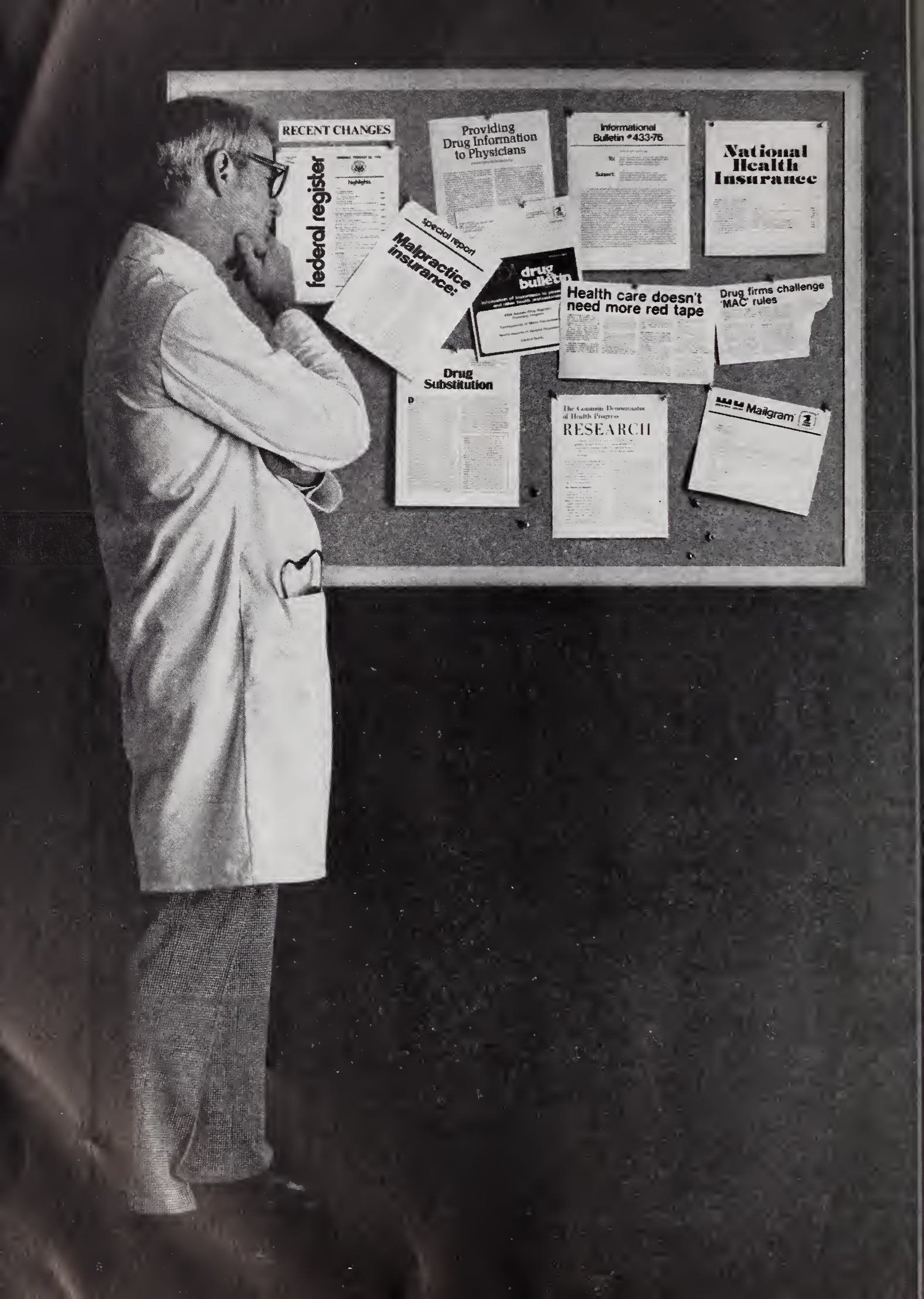
A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

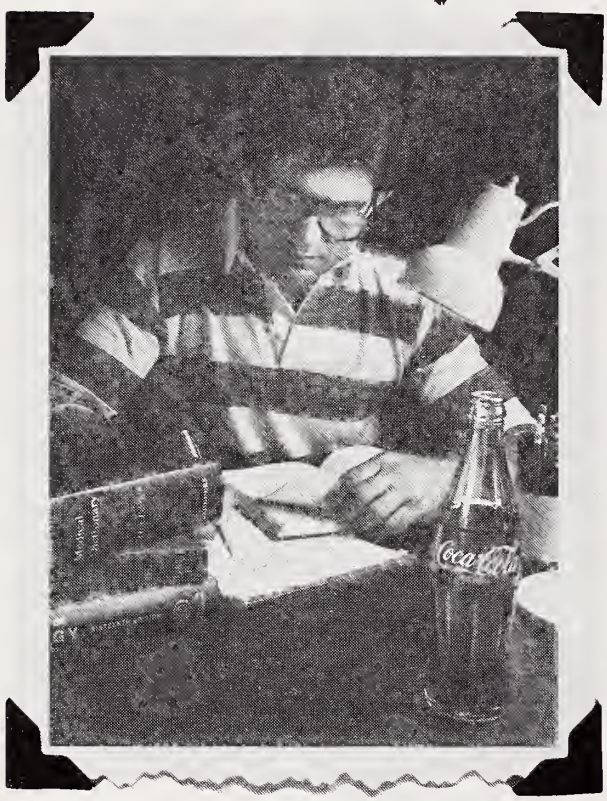
It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Coke adds life to... those special moments.

Trade-marks



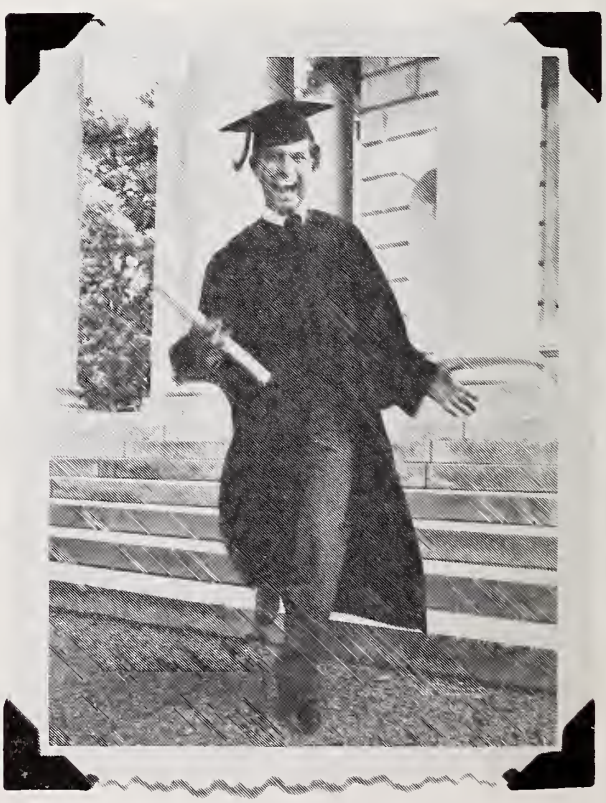
June 2: 2 A.M. Me! Cramming for Inorganic Chemistry finals. Man was I beat!



Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

"Coca-Cola" and "Coke" are registered trade-marks which identify the same product of The Coca-Cola Company

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word. For replies, your name, address and phone number should be included at the end, or an Ad number at the *Journal* may be substituted at no extra cost.

TAX DEDUCTIBLE VACATIONS for medical professionals. Listings of over 500 national/international meetings in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

GEORGIA. Position available for General Practitioner interested in Psychiatry; also Staff Psychiatrist. This is a new 300-bed JCHA approved state psychiatric hospital. Full range of State employee benefits including retirement system and fringe benefits. Salary commensurate with training and experience. An equal opportunity employer. Georgia license or eligibility for license in Georgia required. Contact: *Dr. Henry F. Yost*, Supt., Georgia Regional Hospital at Augusta, P. O. Box 5826, Augusta, Georgia 30906.

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344



METROPOLITA
PSYCHIATRIC

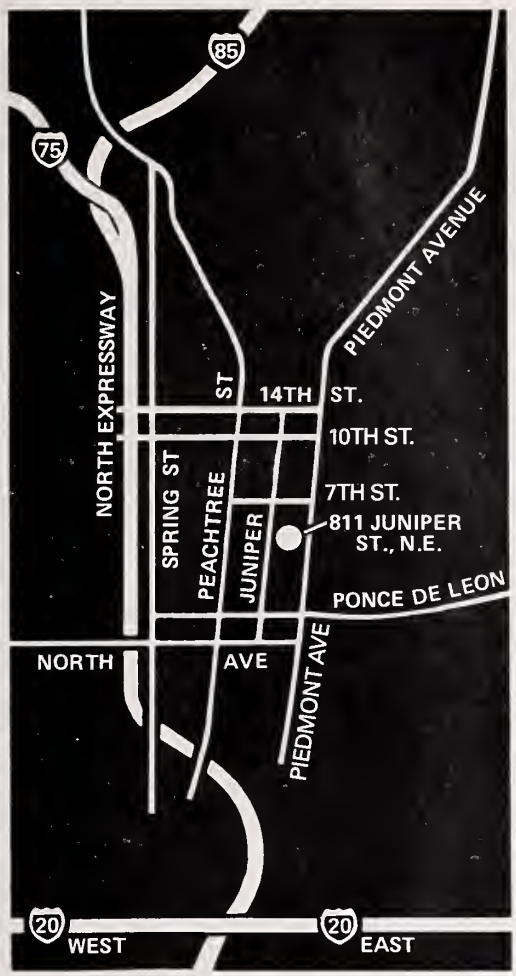
METROPOLITAN PSYCHIATRIC CENTER, c
located in midtown Atlanta, provides comprehe
services for adult and adolescent patients in the a
psychiatry and alcohol and drugs. Inpatient care
patient care and partial hospitalization programs
available at the Center.

In the Psychiatric Program, the attending psychi
determines from the comprehensive services av
the most appropriate modality(s) of treatment, b
always within the theme of individualized care.

The following services are available through the
psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

ily Counseling
chological Testing
ial Work Services
cational Tutoring
ational Rehabilitation Counseling
Radiology Services
vity Therapy Programs including Occupational
rapy, Recreational Therapy and Art Therapy

Metropolitan Alcohol and Drug Program, directed
rd recovery, offers a structured, comprehensive
oach to the treatment of the physical, psychologi-
cal, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

Ehik, M.D. — Scott Patterson, M.D.
al Director — Associate Medical Director

glas Talbott, M.D., F.A.C.P. — Benjamin H. Underwood
or, Alcohol and Drug Services — Administrator

olitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
niper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

Index to Advertising

Vol. 66 January 1977 No. 1

Walter Ballard Optical Company 49

Beltone Electronics Corporation 11

Brawner Hospital, Inc. 4

Burroughs Wellcome Co. 14

Coca-Cola Company 48

Dickey-Mangham Company 43

Dorsey Laboratories 9, 10

Eager and Simpson 43

Georgia Baptist Medical Center 15

Georgia Society of CPAs 6

Hill Crest Hospital 45

Eli Lilly and Company 16

Merck, Sharp & Dohme 7, 8

Metropolitan Psychiatric Center 50, 51

Ortega Pharmaceutical Company, Inc. 45

Pharmaceutical Manufacturers Association 46, 47

Potter-Holden & Company 3

Practice Productivity, Inc. 49

Roche Laboratories ..... 2, 12, 53, Back Cover

Smith, Kline & French 13

Valley Psychiatric Hospital 3

Weight Watchers of Greater Atanta 3

Willingway Hospital 42

JOURNAL
of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

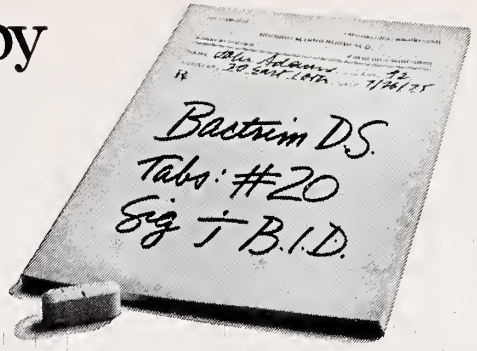
ILLUSTRATIONS—Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

0-day Bactrim therapy outperforms 10-day ampicillin therapy.



a multicenter, double-blind study of patients with hronic or frequently recurrent urinary tract infection, actrim 10-day therapy outperformed ampicillin)-day therapy by 27.2%, when comparing patients ho maintained clear cultures for eight weeks. riterion for "clear culture" was 1000 or fewer organ-ms/ml of urine.

While adverse reactions noted in this study were ild (*e.g.*, vomiting, nausea, rash), more serious reac-)ns can occur with these drugs. See manufacturer's roduct information for complete listing. Maintain dequate fluid intake; perform frequent CBC's and rinalyses with microscopic examination.

)te: Bactrim tablets were used in these clinical trials. Bioequiv-ency studies show one Bactrim DS double strength tablet is quivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

efore prescribing, please consult complete product information, a immary of which follows:

dications: Chronic urinary tract infections evidenced by persistent icteriuria (symptomatic or asymptomatic), frequently recurrent infec-)ns (relapse or reinfection), or infections associated with urinary act complications, such as obstruction. Primarily for cystitis, pyelo-ephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-nterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus organii.*

OTE: The increasing frequency of resistant organisms limits the use-ulness of antibacterials, especially in these urinary tract infections. he recommended quantitative disc susceptibility method (*Federal egister,* 37:20527-20529, 1972) may be used to estimate bacterial usceptibility to Bactrim. A laboratory report of "Susceptible to tri-ethoprim-sulfamethoxazole" indicates an infection likely to respond Bactrim therapy. If infection is confined to the urine, "Intermedi-e susceptibility" also indicates a likely response. "Resistant" indi-ates that response is unlikely.

ontraindications: Hypersensitivity to trimethoprim or sulfonamides; regnancy; nursing mothers.

arnings: Deaths from hypersensitivity reactions, agranulocytosis, plastic anemia and other blood dyscrasias have been associated ith sulfonamides. Experience with trimethoprim is much more mited but occasional interference with hematopoiesis has been re-orted as well as an increased incidence of thrombopenia with pur-ura in elderly patients on certain diuretics, primarily thiazides. ore throat, fever, pallor, purpura or jaundice may be early signs of erious blood disorders. Frequent CBC's are recommended; therapy hould be discontinued if a significantly reduced count of any formed ood element is noted. **Data are insufficient to recommend use in in-nts and children under 12.**

recautions: Use cautiously in patients with impaired renal or hepatic nction, possible folate deficiency, severe allergy or bronchial sthma. In patients with glucose-6-phosphate dehydrogenase defi-ency, hemolysis, frequently dose-related, may occur. During ther-py, maintain adequate fluid intake and perform frequent urinalyses, ith careful microscopic examination, and renal function tests, par-cularly where there is impaired renal function.

iverse Reactions: All major reactions to sulfonamides and trimeth-prim are included, even if not reported with Bactrim. *Blood dys-asias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, rombopenia, leukopenia, hemolytic anemia, purpura, hypopro-rombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

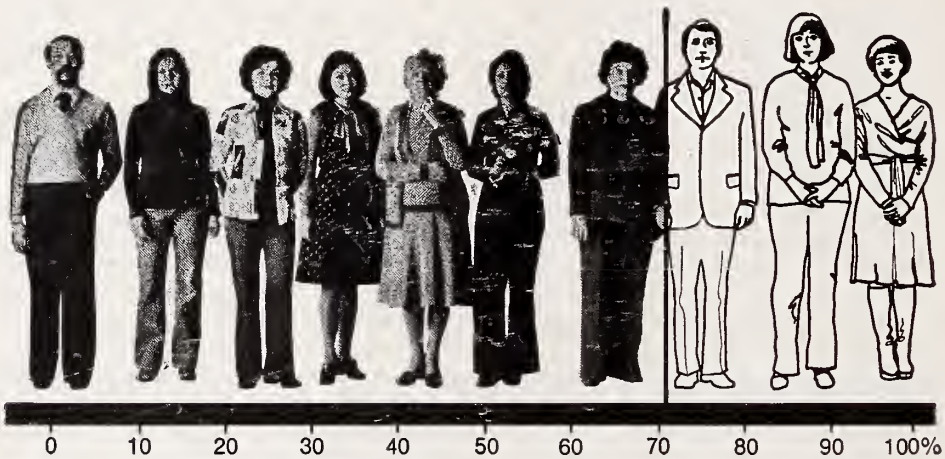
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

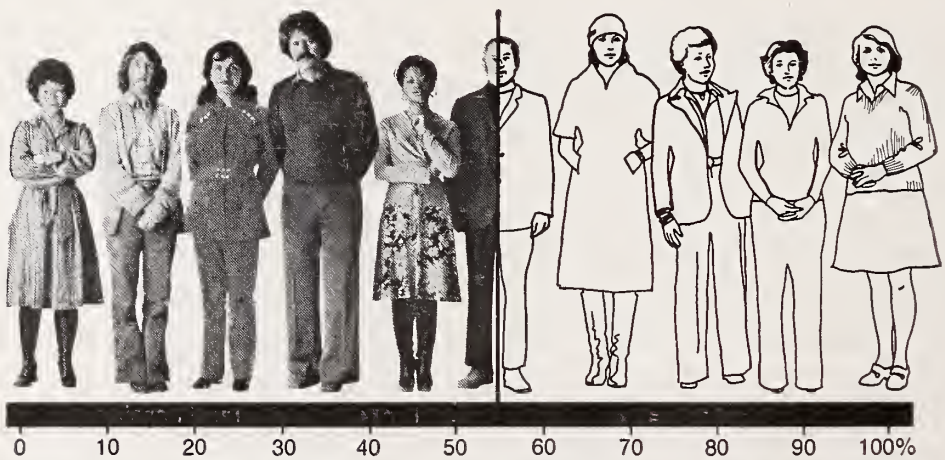
In a multicenter study of patients with chronic or frequently recurrent urinary tract infec

CALIF., SAN FRANCISCO
SAN FRANCISCO, CA. 94143

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

ROCHE

JOURNAL of the medical association of georgia

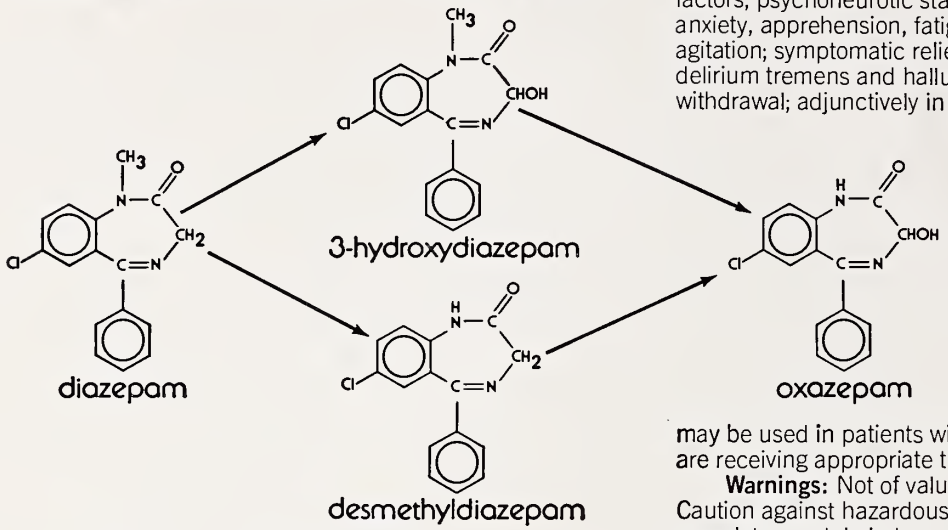
FEBRUARY / 1977



MAG Annual Session
AMAG Annual Convention
Macon/April 22-24, 1977

LIBRARY
U.C. SAN FRANCISCO

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

When it's pinworms, treat the family



ef Summary of
scribing Information

ions: Pyrvinium
noate appears to exert
anthelmintic effect by
venting the parasite
n using exogenous
ohydrates. The para-
's endogenous reserves
depleted, and it dies.
an is not appreciably
orbed from the gastro-
stinal tract.

ication: Povan is indi-
ed for the treatment of
erobiasis.

nings: No animal or
nan reproduction
dies have been per-
ned. Therefore, the use
is drug during preg-
cy requires that the
ential benefits be
ghed against its pos-
e hazards to the mother
fetus.

cautions: To forestall
ue concern and help
id accidental staining,
ents and parents
uld be advised of the
ning properties of
an. Care should be
rcised not to spill the
pension because it will
n most materials.
ets should be swal-
ed whole to avoid
ning of teeth. Parents
patients should be
rmed that pyrvinium
oate will color the
l a bright red. This is
harmful to the patient.
nesis occurs, the
nitus will probably be
ored red and will stain
t materials.

erse Reactions:
sea, vomiting, cramp-
diarrhea, and hyper-
sitivity reactions (pho-
nsitization and other
gic reactions) have
n reported. The gastro-
stinal reactions occur
e often in older chil-
n and adults who have
ived large doses.
esis is more frequently
n with Povan Suspen-
than with Povan
seals.

Supplied: Each
an Filmseal® contains
inium pamoate equiva-
to 50 mg pyrvinium,
plied in bottles of 50
C 0710-0747-50;
N 6505-00-134-1966).
an Suspension, a
sant-tasting, straw-
y-flavored preparation
taining pyrvinium
oate equivalent to
g pyrvinium per milli-
is supplied in 2-oz
les (NDC 0071-1254-31;
N 6505-00-890-1093).

PD-JA-1699-2-P (8-76)

e, Davis & Company
roit, Michigan 48232

Povan® (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

BRAWNER HOSPITAL, INC.

Established 1910

3180 ATLANTA STREET, S.E.
SMYRNA, GEORGIA 30080
Telephone 404 436-0081



Located in the metropolitan Atlanta area, this psychiatric hospital is staffed by the members of the Center for Interpersonal Studies, P.A. Emphasis is placed on individual and group psychotherapy on an intensive basis. Each patient is assigned a staff psychiatrist who is responsible for the planning of an individualized treatment program, coordination of the assets of the therapeutic community and a continuing liaison with the patient's family and referring physician.

A comprehensive range of services is provided. There are facilities for evaluation and intensive treatment of patients with emotional problems which can be managed in an open psychiatric facility. An accredited high school is located on the hospital grounds and efforts are made to coordinate work with the local school system.

Member of the American Hospital Association and the National Association of Private Psychiatric Hospitals.

Accredited by the Joint Commission on Accreditation of Hospitals.

Mark A. Gould, M.D.
Medical Director

William H. Benson, M.D.
Psychosomatic Medicine

Ronald C. Bloodworth, M.D.
Psychiatry

Herbert Gorod, M.D.
Psychiatry

Karl S. Mihalovits, M.D.
Clinical Director

Jesse R. Peel, M.D.
Psychiatry

Harry Porter, Jr., M.D.
Psychiatry

Frederick W. Huff, Ph.D.
Psychology

JOURNAL
of the medical association of georgia

contents

VOLUME 66, Number 2

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF COUNCIL
Fleming L. Jolley
President
Robert E. Perry, Jr., M.D., Brunswick
President-Elect, Chairman of Council
David A. Wells, M.D., Dalton
Immediate Past President
James H. Sullivan, M.D., Columbus
First Vice President
Milton I. Johnson, M.D., Macon
Second Vice President
Earnest C. Atkins, M.D., Atlanta
Secretary
Carson B. Burgstiner, M.D., Savannah
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Ronald F. Galloway, M.D., Augusta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
L. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 201-05 Bluff Street, Fulton, Missouri 65251.

1977 ANNUAL SESSION AND AMAG ANNUAL CONVENTION

73 Official Call

75 Officials of the Association

76 Component County Society Representatives to the 1977 House of Delegates

77 Criteria for Selection of Recipients of MAG Awards

78 Official Program

80 Auxiliary 52nd Annual Convention, Greetings and Schedule

82 Hotel Reservation Form

83 Macon

SCIENTIFIC ARTICLE

85 Three Causes of Syncope of One Patient, Detected by Holter Monitoring
Laurence Lesser, M.D.
Nanette K. Wenger, M.D.

SPECIAL ARTICLES

87 Pre-Hospital Emergency Care in Georgia: A Status Report
Charles B. Mosher, M.D.

89 The Addison M. Duval Library May Be Able to Help You
Edward J. D'Anna, M.S.L.S.

EDITORIALS

91 Delineation of Fees According to Geographical Areas
Charles D. Hollis, Jr., M.D.

92 Rising Costs: Private Medicine's Vunerable Spot
AMA

93 New Managing Editor for the JOURNAL
Edgar A. Woody, Jr., M.D.

FEATURES

94 President's Letter/Let Me Hear From You
Fleming L. Jolley, M.D.

98 Cancer Page/The Changing Picture of Malignant Melanoma
William J. Pendergrast, M.D.

100 Heart Page/When It's Heart Attack Every Minute Counts
Joe M. Turner, M.D.

102 Legal Page/Estate Planning Aspects of the Tax Reform Act of 1976
William Linkous, Jr.
Eric P. Neuman

105 I've Told This Before/A Retiree's Lunch
J. G. McDaniel, M.D.

THE ASSOCIATION

106 New Members

107 Societies

107 Personals

107 Deaths

NEWS

95 Report on the Clinical Meeting of the AMA

99 Ask Medicare

101 Heart Bypass Operations Top 1,000 Mark at Emory

112 Opportunities in Continuing Medical Education

THE COVER

"Fort Hawkins from 1806 to 1821," drawn by E. D. Ervine of Macon for Butler's *History of Macon and Central Georgia,* copyrighted 1879.

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, electro-convulsive therapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least two days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
Davis G. Garrett, M.D.
Henry Evans, M.D.

Clinical Psychology
Michael J. Cutler, Ph.D.
Thomas L. Cory, Ph.D.

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

R. Lindsay Shuff, M.H.A.
Administrator



BREATHING WITH COMFORT.

Choledyl—a highly soluble, true salt of theophylline—rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION. Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline, alcohol 20%. *Indications.* Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. *Warning.* Use in pregnancy—animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. *Precautions.* Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. *Adverse Reactions.* Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. *Dosage.* Average adult dosage: Tablets—200 mg 4 times a day, Elixir—two teaspoonfuls, 4 times a day. *Supplied.* 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60), Unit Dose—200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir—bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). *Toxicity.* Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C

WARNER/CHILCOTT
Division Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL®
(OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

Famous Fighters



NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



"I Cannot Tell A Lie—It Does Taste Like BANANAS!"

When acute, non-specific diarrhea causes the stomach to revolt, the tasteful counterattack is Donnagel®-PG. Donnagel-PG provides all the benefits of paregoric and—instead of that unpleasant paregoric taste—a delicious banana flavor good enough to make even an expert flip his wig.

Now with child-proof closure

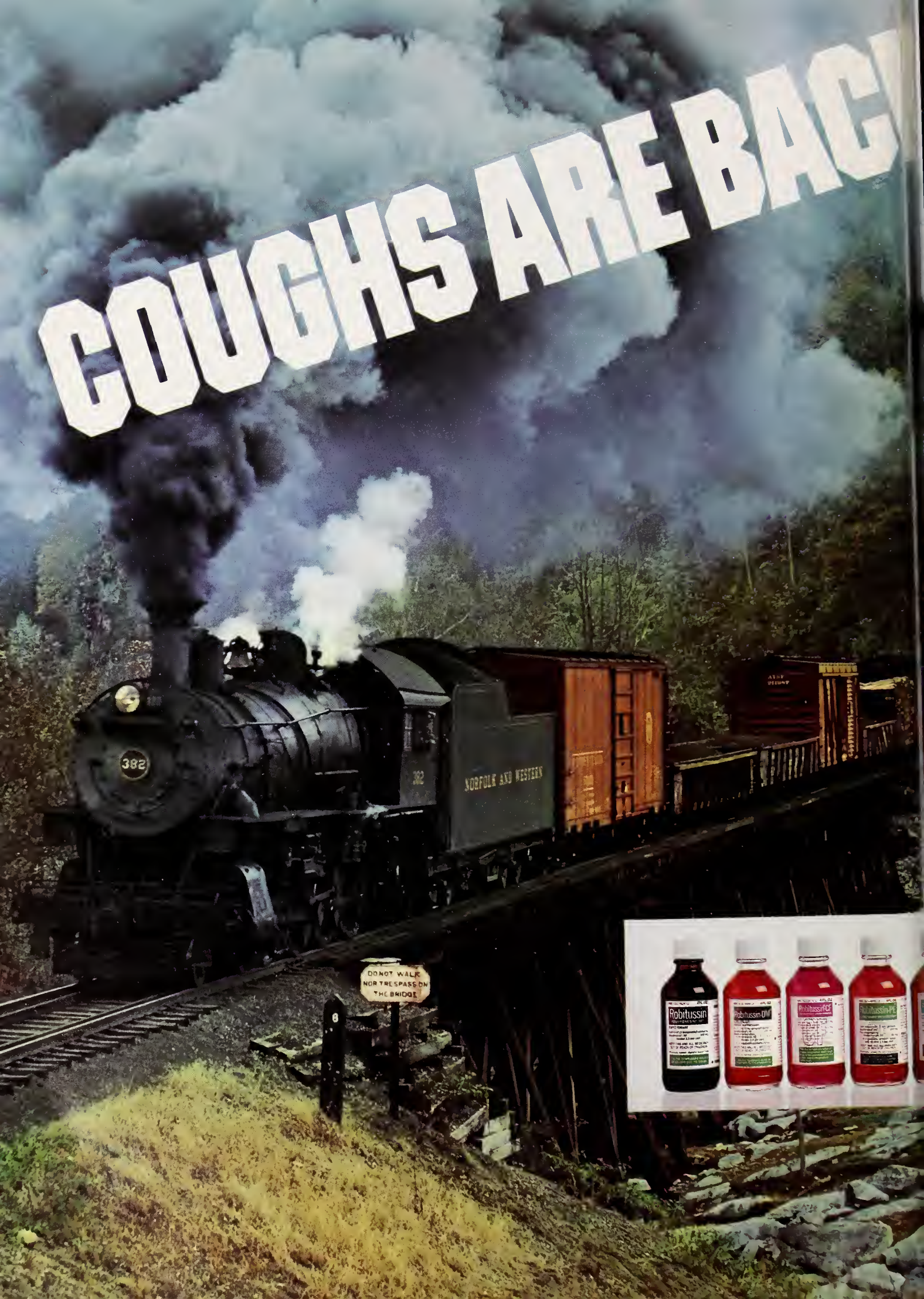
Donnagel®-PG℣

Donnagel with paregoric equivalent

For diarrhea

Each 30 ml. contains:	
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
(warning: may be habit forming)	
Sodium benzoate	60.0 mg.
(preservative)	
Alcohol, 5%	

A·H·ROBINS A.H. Robins Company, Richmond, Virginia 23220 Member of Certified Medical Representatives Institute


COUGHS ARE BAC
382
382
NORFOLK AND WESTERN
DO NOT WALK
NOR TRESPASS ON
THE BRIDGE
Robitussin
Robitussin-DM

CLEAR THE TRACT

coughs of colds, i" and u.r.i.— ear the tract h the famous bitussin® Line!

5 members of the tussin® family all contain expectorant, guaifenesin, lp clear the lower iratory tract. Guaifenesin ks systemically to help ulate the output of lower iratory tract fluid. This anced flow of less viscid etions promotes ciliary n and makes thick, issated mucus less viscid easier to raise. As a lt, dry, unproductive ghs become more uctive and less frequent.

For productive and unproductive coughs

Robitussin®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Alcohol, 3.5%

For severe coughs

Robitussin A-C®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Codeine Phosphate, USP ..... 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hour cough control

Robitussin-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Dextromethorphan
Hydrobromide, NF ..... 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus openings as it helps relieve coughs

Robitussin-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 100 mg
Pseudoephedrine
Hydrochloride, NF ..... 30 mg
Alcohol, 1.4%

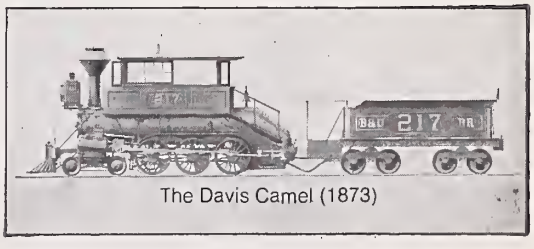
Decongestant action helps control cough and clear stuffy noses and sinuses. Non narcotic.

Robitussin-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF ..... 50 mg
Phenylpropanolamine
Hydrochloride, NF ..... 12.5 mg
Dextromethorphan
Hydrobromide, NF ..... 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

OTO: Norfolk & Western Branch Train west bound near Alvarado, Va. (Oct., 1956). reaches the highest point of any railroad he Rockies (elevation 3,577 ft.) with a n grade of 3%. It crosses 108 bridges, 0 ft. long! Photo by O. Winston Link.

A·H·ROBINS

A. H. Robins Company, Richmond, Va. 23220



METROPOLITAN PSYCHIATRIC

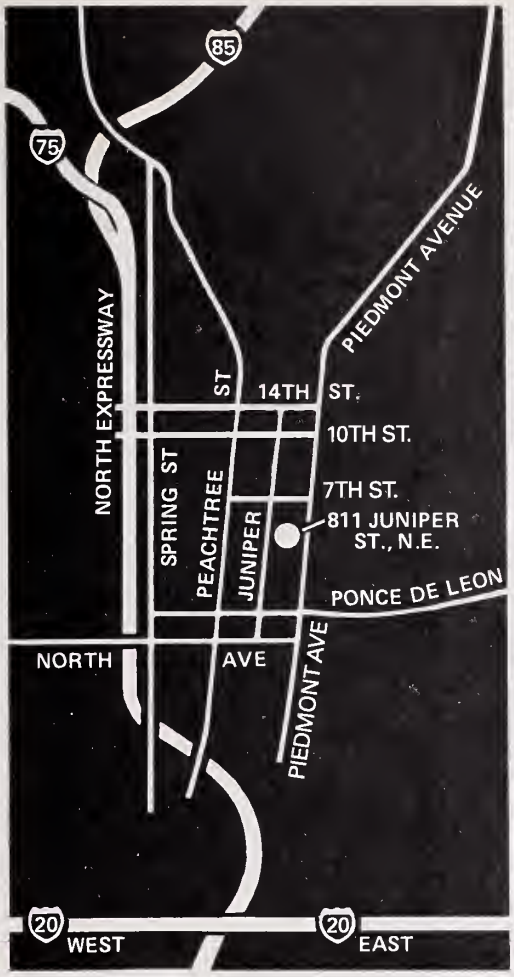
METROPOLITAN PSYCHIATRIC CENTER, ce
located in midtown Atlanta, provides compreher
services for adult and adolescent patients in the a
psychiatry and alcohol and drugs. Inpatient care,
patient care and partial hospitalization programs
available at the Center.

In the Psychiatric Program, the attending psychia
determines from the comprehensive services av
the most appropriate modality(s) of treatment, b
always within the theme of individualized care.

The following services are available through the
psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

nily Counseling
ychological Testing
cial Work Services
ucational Tutoring
cational Rehabilitation Counseling
ll Radiology Services
tivity Therapy Programs including Occupational
erapy, Recreational Therapy and Art Therapy

Metropolitan Alcohol and Drug Program, directed
ard recovery, offers a structured, comprehensive
roach to the treatment of the physical, psychologi-
cal, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

Grumet, M.D.
ical Director

Custis L. Rosser, M.H.A.
Administrator

Douglas Talbott, M.D., F.A.C.P.
ctor, Alcohol and Drug Services

opolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

MAG SERVICES INCORPORATED

QUALITY AND INEXPENSIVE

PRINTING SERVICES FOR DOCTORS

LETTERHEADS

20 LB. WHITE BOND				
SIZE	**500**	**1000**	**2000**	**4000**
7¼ x 10½ 8½ x 11	11.16	15.70	24.98	42.72
20 LB. RAG CONTENT (25%)				
7¼ x 10½ 8½ x 11	13.90	21.16	35.91	64.75

ENVELOPES

TO MATCH LETTERHEADS

24 LB. WHITE WOVE				
SIZE	**500**	**1000**	**2000**	**4000**
6¾	12.88	15.96	25.51	47.90
Monarch	13.70	17.59	28.76	54.40
#10	13.77	17.74	29.06	55.00
20 LB. RAG CONTENT				
Monarch	20.23	30.63	54.86	106.60
#10	20.86	33.97	57.43	111.75

WINDOW ENVELOPES

24 LB.

SIZE	500	1000	2000	4000
6¾	13.83	17.84	29.26	55.40
#10	14.85	19.89	33.36	63.60

Composition and type set charges are in addition to quoted prices.

UNIFORM INSURANCE CLAIM FORMS (Approved by AMA)

$18.50/1000 — Single Copies — Pads of 100

SEND ORDERS TO:

MAG SERVICES, INC.

(a service company of the Medical Association of Georgia)

968 PEACHTREE ST., N.E.
ATLANTA, GA. 30309
(404) 873-4136

ATTENTION PHYSICIANS

If you are interested in joining a major Primary Care Group Practice in Houston or Dallas . . . the I*MED Program is the answer.

I*MED, INC. is currently constructing five Primary Care Clinics in Houston and Dallas with exceptional Physician opportunities . . .

*Guaranteed Base Salary

*Percent of Revenue

*Paid Professional Liability Insurance

*No Overhead

*Shared Call

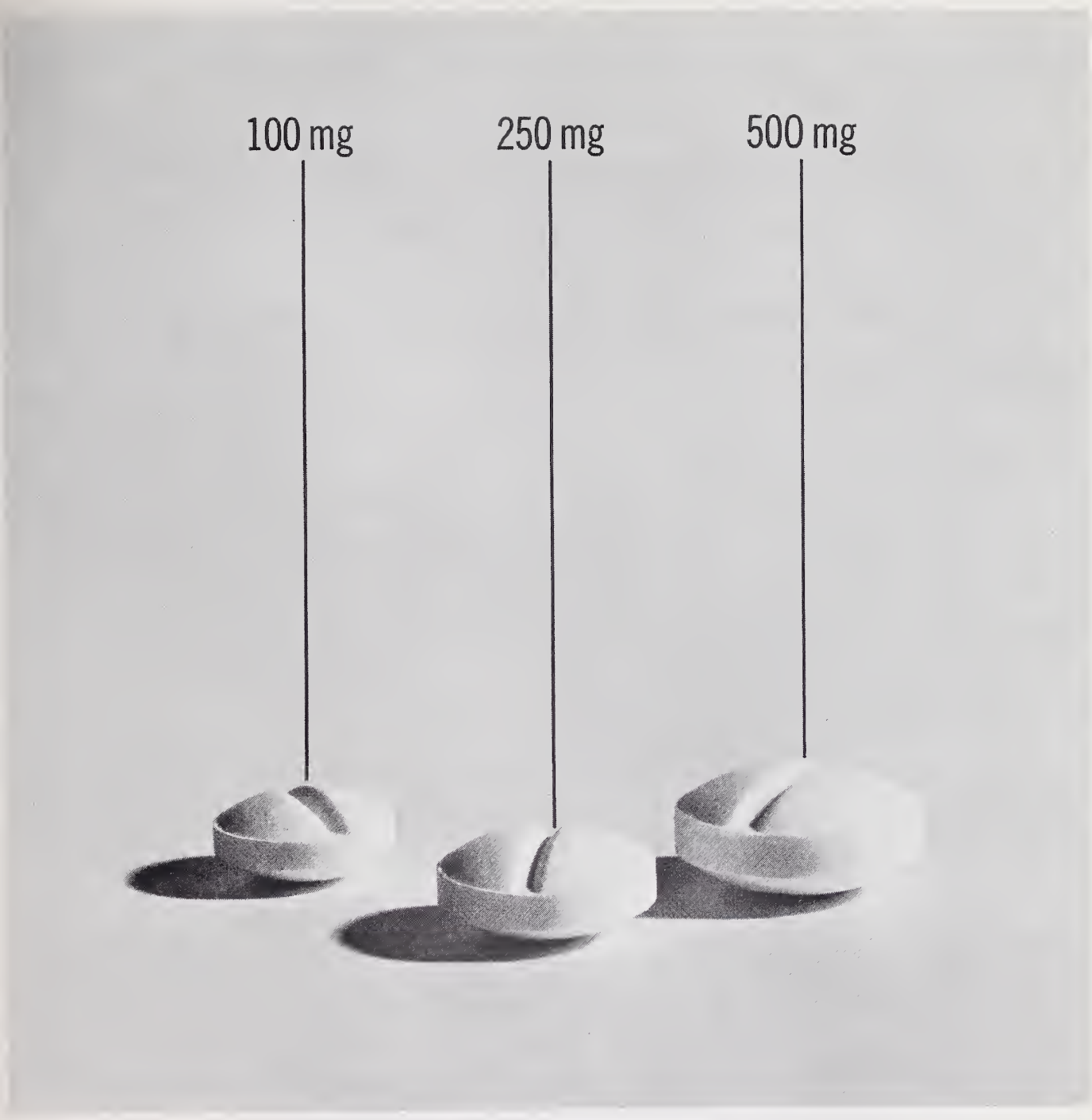
*Peer Group Practice
. . . and more

Interested Physicians Contact:

Stephen C. Smith

I*MED, INC.

10910 Katy Road
Houston, Texas 77043
(713) 932-1111



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-G

©1977 THE UPJOHN COMPANY



When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is ıe most widely prescribed agent for the ıanagement of vertigo* associated with dis-ıses affecting the vestibular system such ; Menière's disease, labyrinthitis, and ves-ıular neuronitis.

▪ **Relief of Nausea and Vomiting**—ntivert/25 can relieve the nausea and ›miting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult ›sage for Antivert/25 is one tablet t.i.d.

IEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

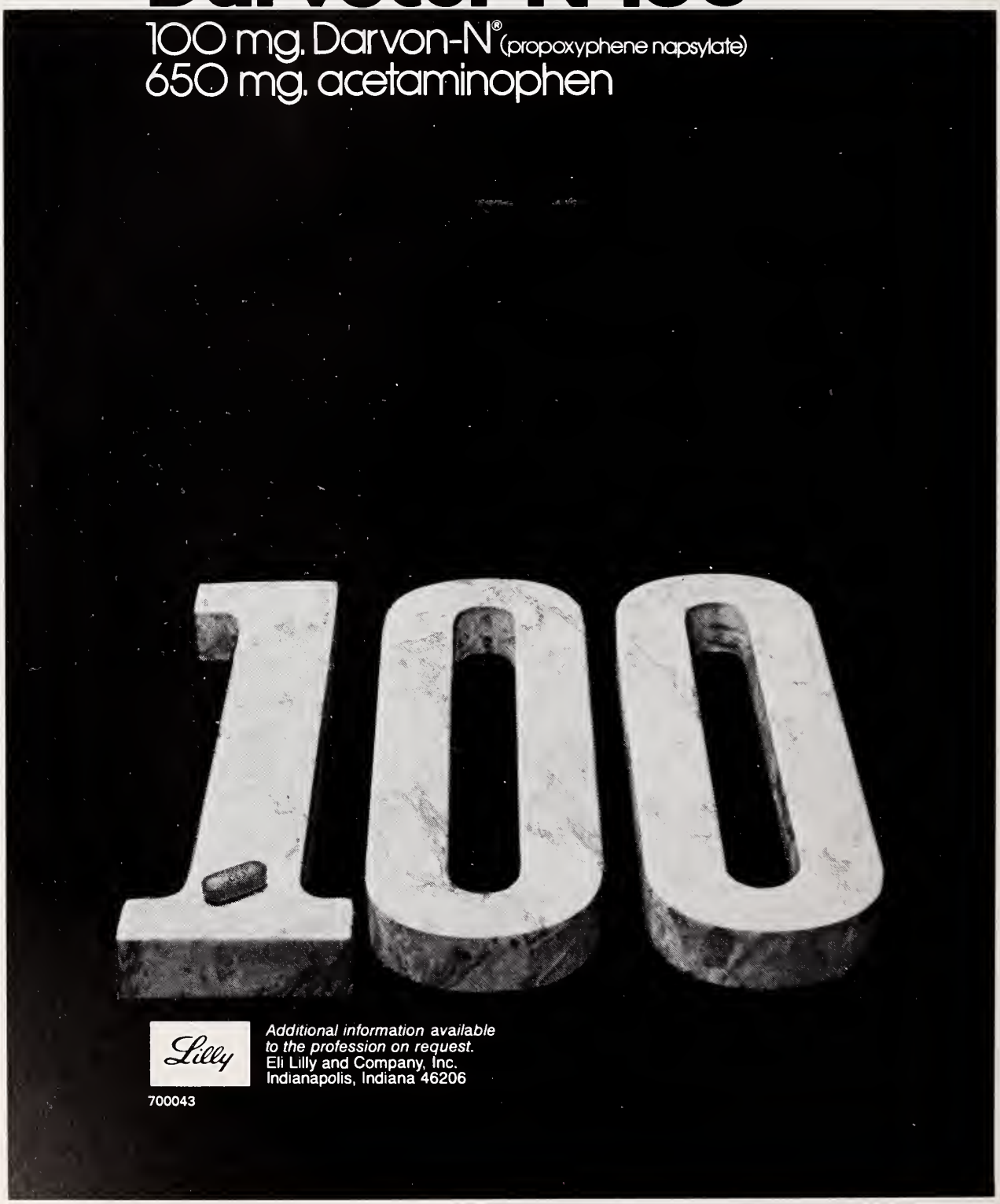
ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

contains no aspirin

tablets

Darvocet-N® 100

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request.
Eli Lilly and Company, Inc.
Indianapolis, Indiana 46206

700043

Official Call

To the Officers, Delegates, and Members of the Medical Association of Georgia to attend the 123rd Annual Session of the House of Delegates

In Macon, Georgia

April 22, 23 & 24, 1977

The House of Delegates will convene at 10:30 a.m. on Friday, April 22, in the Grand Ballroom of the Macon Hilton Hotel. The Annual Session will confine itself to the business affairs of the Association. Scientific Activities will take place during the Annual Scientific Assembly to be held in November, 1977 in Atlanta.

General Sessions

The Opening Session will be called to order by President Fleming L. Jolley, M.D. at 9:00 a.m. on Friday, April 22, in the Grand Ballroom of the Macon Hilton Hotel. Featured during this session will be the presentation of the Association Awards, Report of the President of the Auxiliary, Mrs. Milton F. Bryant, incoming President of MAG, Robert E. Perry, Jr., M.D., and an Address by Richard E. Palmer, M.D., President of the American Medical Association.

The Second General Session will follow the adjournment of the House of Delegates on Sunday, April 23. At this time the newly elected officers will be installed.

House of Delegates

The First Session of the House of Delegates will convene on Friday, April 22, at 10:15 in the Grand Ballroom. During this first session, nominations for MAG Officers will be accepted; reports of officers and committees will be presented; resolutions and other new business will be placed before the House. Reference Committees will be appointed and all business will be referred to the appropriate Committees by the Speaker.

The Second Session of the House will take place on Saturday, April 23, at 1:30 p.m. in the Grand Ballroom. The House will consider those Reference Committee Reports that have been completed by this time.

The Third and Final Session will begin at 9:00 a.m. on Sunday, April 24, in the same meeting room. Reference Committee Reports will be completed at this time and the newly elected MAG officers will be announced.

Reference Committee

Open Hearings will be held beginning at 1:00 p.m. Friday, April 22, in various meeting rooms at the Macon Hilton. All members of the Association are invited to appear before the Reference Committees to express their views. The bylaws direct that all reports and resolutions presented to the House of Delegates must be referred by the Speaker to a Reference Committee.

Election of Officers

Nominations of the candidates for the offices of the Association will be made during the First Session of the House of Delegates Friday, April 22. The election will take place on Sunday, April 24, before the reconvening of the House for the Third and Final Session, Sunday, April 24. The polls will be located in the Grand Foyer. Delegates will be certified by the Credentials Committee and vote by secret ballot any time between 7:00 a.m. and 9:00 a.m. When the polls close at 9:00 a.m., the Tellers Committee will retire to count the ballots. The election results will be announced to the House at an appropriate time during the morning proceedings.

GaMPAC Brunch

This annual highlight of the Annual Session will be held this year on Saturday morning. Details will be announced as the arrangements are finalized.

President's Reception

The Association will honor its President, Fleming L. Jolley, M.D., at a reception to be held on Saturday, April 22, at 6:30 p.m. in the Grand Ballroom of the Macon Hilton.

Alumni Events

Reception and dinners sponsored by the various medical school alumni associations are often held

during Annual Session. Announcements will be made prior to Annual Session.

Hotel Reservations

The Macon Hilton Hotel has reserved for MAG virtually all of its sleeping rooms for the Annual Session. Additional rooms will be available at the Ramada Inn. MAG Officers, Councilors and Delegates will be given first priority for accommodations at the Macon Hilton. Members of the Auxiliary to MAG will also receive priority consideration for the Macon Hilton. Officers, Councilors, Delegates and Alternate Delegates will be sent special housing forms by the headquarters office. All others should utilize the Housing Form contained in this issue of the JMAG. Late reservations received by the Macon Hilton Hotel, after all rooms at the Macon Hilton have been reserved, will be transmitted to the Ramada Inn.

Registration

Registration for all attendees and Certification of Delegates will take place in the Grand Foyer of the Macon Hilton Hotel during the following hours:

Thursday, April 21 ..... 4:00 p.m.-7:00 p.m.
Friday, April 22 ..... 7:30 a.m.-5:00 p.m.
Saturday, April 23 ..... 8:30 a.m.-5:00 p.m.
Sunday, April 24 ..... 7:00 a.m.-12:00 noon

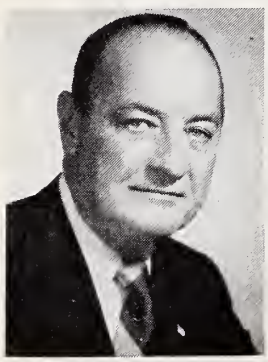
Headquarters Office

The Association staff will maintain an office in the Camelia Room located on the Garden level of the Macon Hilton.

Message Center

The Auxiliary to MAG will operate a Message Desk for the convenience of the members in the Grand Foyer of the Macon Hilton during the same hours as the Registration Desk is open. Messages will be posted on a bulletin board at the Message Desk. Members are urged to inform the Message Desk as to their location, if they are expecting a message.

AMA PRESIDENT RICHARD E. PALMER



GUEST SPEAKER at Friday's opening General Session is Richard E. Palmer, M.D., 1976-77 President of the American Medical Association.

Dr. Palmer is a pathologist from Alexandria, Virginia, where he has practiced at Alexandria Hospital since 1949 and at Circle Terrace Hospital Laboratory since 1955. Prior to his election at the 1975 AMA Annual Convention in Atlantic City, he had been Chairman of the Board of Trustees since 1973. He also served as a member of the AMA Council on Medical Service and its Committees on Health Care of the Poor and Government Medical Service in 1969-70.

In February 1974, he was installed as President of the International Academy of Pathology. He has also been President of the Alexandria Medical Society, the Alexandria Chapter of the American Cancer Society, the American Society of Clinical Pathologists, Medical Society of Virginia, George Washington University Medical Alumni Association and the Private Practitioners of Pathology Foundation.

This distinguished gentleman has received many awards for meritorious service and achievement, and as President of the AMA during these uneasy times has important and interesting information to impart. MAG is proud to have him as a guest speaker.

Officers of the Association
1976-1977



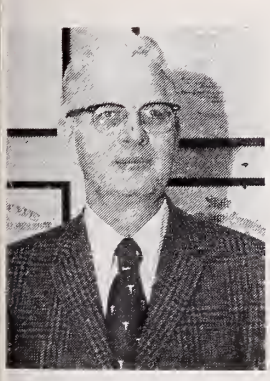
JOLLEY



PERRY



WELLS



JOHNSON



SULLIVAN



ATKINS



BURGSTINER



BUCHANAN



GALLOWAY



WOODY

OFFICERS

Position		*Term Ending*
PRESIDENT	Fleming L. Jolley, Atlanta	1977
PRESIDENT-ELECT	Robert E. Perry, Jr., Brunswick	1977
IMMEDIATE PAST PRESIDENT	David A. Wells, Dalton	1979
PAST PRESIDENT	J. Rhodes Haverty, Atlanta	1978
PAST PRESIDENT	C. E. Bohler, Brooklet	1977
FIRST VICE PRESIDENT	James H. Sullivan, Columbus	1977
SECOND VICE PRESIDENT	Milton I. Johnson, Macon	1977
CHAIRMAN OF COUNCIL	Robert E. Perry, Jr., Brunswick	1977
SECRETARY	Earnest C. Atkins, Atlanta	1978
TREASURER	Carson B. Burgstiner, Savannah	1978
SPEAKER OF THE HOUSE	L. C. Buchanan, Decatur	1977
VICE SPEAKER OF THE HOUSE	Ronald F. Galloway, Augusta	1977
EDITOR, *JMAG*	Edgar Woody, Jr., Atlanta	1977

COUNCILORS AND VICE COUNCILORS

District	*Councilors*	*Vice Councilors*	
1	Leon E. Curry, Metter	Chas. R. Richardson, Statesboro	1979
2	J. Dan Bateman, Albany	Sammie Dixon, Tifton	1979
3	John H. Robinson, Americus	B. Lamar Pilcher, Warner Robins	1979
6	James M. Skinner, Griffin	Norman P. Gardner, Thomaston	1977
7	Don Schmidt, Cedartown	Richard A. Griffin, Cartersville	1977
8	Joe C. Stubbs, Valdosta	Fred C. Smith, Valdosta	1977
9	Harvey M. Newman, Gainesville	L. Austin Flint, Canton	1978
10	Edwin W. Allen, Jr., Milledgeville	M. A. Hubert, Athens	1978
Bibb County Medical Society:			
	Milton I. Johnson, Macon	Beverly B. Sanders, Macon	1978
Cobb County Medical Society:			
	Charles R. Underwood, Marietta	Frank W. McKinnon, Marietta	1978
DeKalb County Medical Society:			
	Luther M. Vinton, Avondale Estates	Stanley P. Aldridge, Decatur	1978
Floyd-Polk-Chattooga Medical Society:			
	John I. Dickinson, Rome	Lee H. Battle, Rome	1978
Medical Association of Atlanta:			
	John T. Godwin, Atlanta	J. Norman Berry, Sandy Springs	1977
	T. J. Anderson, Jr., Atlanta	William D. Logan, Atlanta	1978
	J. Harold Harrison, Atlanta	William C. Waters, III, Atlanta	1979
Georgia Medical Society:			
	Joseph A. Mulherin, Savannah	Joe L. Nettles, Savannah	1979
Muscogee County Medical Society:			
	Jack A. Raines, Columbus	Louis A. Hazouri, Columbus	1977
Richmond County Medical Society:			
	Ronald F. Galloway, Augusta	Henry D. Scoggins, Augusta	1978

AMA DELEGATES AND ALTERNATE DELEGATES

Delegate	*Term Ending*	*Alternate Delegate*	*Term Ending*
C. Emory Bohler, Brooklet	12-31-77	F. G. Eldridge, Valdosta	12-31-77
F. D. Dowda, Atlanta	12-31-77	Charles D. Hollis, Albany	12-31-77
Harrison L. Rogers, Atlanta	12-31-78	H. Hilt Hammett, LaGrange	12-31-78
J. Dan Bateman, Albany	12-31-78	W. W. Moore, Atlanta	12-31-78

Component County Society Representation to the 1977 House of Delegates

(1976 CMS Member Count for 1977 Delegates to Annual Session—Tentative)

County Society	*Number of Delegates*	*County Society*	*Number of Delegates*
Altamaha	1	Cherokee-Pickens	1
Baldwin	3	Crawford W. Long	4
Barrow	1	Clayton-Fayette	2
Bartow	1	Cobb	9
Ben Hill Irwin	1	Coffee	1
Bibb	9	Colquitt	1
Ogeechee	2	Coweta	2
Burke	1	Decatur-Seminole	1
Carroll-Douglas-Haralson	2	DeKalb	11
Georgia Medical Society	10	Dougherty	1
Elbert	1	Camden-Charlton	1
Chattahoochee	2	Emanuel	1

County Society	Number of Delegates
Flint	1
Floyd-Polk-Chattooga	5
Franklin-Hart	1
Medical Association of Atlanta	45
Glynn	3
Gordon	1
Habersham	1
Hall	4
Peach Belt	2
Jackson-Banks	1
Jefferson	1
Laurens	2
McDuffie	1
Meriwether-Harris-Talbot	1
Mitchell	1
Muscogee	8
Newton-Rockdale	1
Oconee	1
Ocmulgee	1
Randolph-Stewart-Terrell	1
Richmond	14
Screven	1
South Georgia	3
Southeast Georgia	1
Southwest Georgia	1
Spalding	2
Stephens-Rabun	1
Sumter	1
St. John's Parish	1
Telfair	1
Thomas Area	3
Tift	2
Troup	2
Upson	1
Walker-Catoosa-Dade	2
Walton	1
Ware	2
Washington	1
Wayne	1
Whitfield-Murray	3
Wilkes	1
Worth	1

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the active achievement of anyone who in the judgment of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five-man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters no later than March 21, 1977. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented on Friday, April 22. By custom this award usually has gone to a Georgia physician. However, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters Office no later than March 21. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five-man secret committee and presentation will be made on Friday, April 22.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this ward supported by appropriate data which must be received at the MAG Headquarters office no later than March 21. The recipient of this award will be selected by a three-man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made on Friday, April 22.

Family Physician of the Year

This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The name of the family physician, accompanied by supporting biographical data must be received at MAG Headquarters by March 21. The President of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award on Friday, April 22.

Official Program

(All Functions of the House of Delegates will be held in the Macon Hilton)

THURSDAY, APRIL 21

4:00 p.m.-7:00 p.m.	**General and Delegates Registration** *Grand Foyer*

FRIDAY, APRIL 22

7:30 a.m.-5:00 p.m.	**General and Delegates Registration** *Grand Foyer*
9:00 a.m.	**First General Session** *Grand Ballroom* Presiding: Fleming L. Jolley, M.D., President Opening Ceremonies Report of the President of the Auxiliary to the MAG Mrs. Milton F. Bryant Greetings: Mrs. Chester L. Young, President-Elect, Auxiliary to AMA Report and Comments of the President-Elect of the MAG Robert E. Perry, Jr., M.D. Presentation of MAG Awards AMA/ERF Medical Education Funds Family Physician of the Year Hardman Cup Civic Endeavor Award Distinguished Service Award Address: Richard E. Palmer, M.D., President, American Medical Association Announcements Recess
10:30 a.m.	**House of Delegates, 1st Session** *Grand Ballroom* Presiding: L. C. Buchanan, M.D., Speaker, Ronald F. Galloway, M.D., Vice Speaker Presentation, Correction and Adoption of the Minutes of the 1976 House of Delegates Appointment of Convention Committees Reports of Officers and Committees Introduction of New Business Announcements Recess
1:00 p.m.	**Reference Committee Hearings** *Lanier Room, Cherry Room, Walnut Room, Mulberry Room, Iris Room, and Cherokee Room* (Committee Assignments to be announced)

SATURDAY, APRIL 23

8:30 a.m.-5:00 p.m.	**General and Delegates Registration** *Grand Foyer*
To be announced	**GaMPAC BRUNCH** *Grand Ballroom* (All MAG Members, Auxiliary Members, and guests are invited to attend)
1:30 p.m.	**House of Delegates, 2nd Session** *Grand Ballroom* REPORTS OF REFERENCE COMMITTEES
6:30 p.m.	**President's Reception** *Grand Ballroom* (All MAG Members, Auxiliary Members and guests are invited to attend)

SUNDAY, APRIL 24

7:00 a.m.	**General and Delegates Registration** *Grand Foyer*
7:00 a.m.-9:00 a.m.	**Polls Open for Election of Association Officers and AMA Delegates** *Grand Foyer*
9:00 a.m.	**House of Delegates, 3rd Session** *Grand Ballroom* Invocation Reports of Reference Committees Announcements of Election Results Announcements Adjournment
12:00 noon	**General Session, Final** *Grand Ballroom* Presiding: Fleming L. Jolley, M.D., President Installation of Officers Adjournment of 123rd Annual Session

Auxiliary 52nd Annual Convention

April 21-23, 1977 · Hilton Hotel · Macon, Georgia

President's Greeting



AN INVITATION is most cordially extended to all spouses of members of the Medical Association of Georgia to attend the 52nd Annual Convention of the Auxiliary to the Medical Association of Georgia.

A formal invitation—yes, most certainly—but an invitation to come together in a spirit of friendship and a chance to share a glow of accomplishment rarely surpassed. This convention is for you! The members of the Auxiliary to the Bibb County Medical Society are prepared to make it a memorable occasion. We are honored to be able to have as our special guest Mrs. Chester L. Young, President-elect, Auxiliary to the American Medical Association.

It will all happen in Macon, Georgia, April 21-23, 1977 at the Macon Hilton Hotel. Please join us!

Mrs. Milton F. Bryant, Jr.
President
Auxiliary to the Medical
Association of Georgia

Welcome to Macon



THE MEMBERS of the Bibb County Auxiliary join me in welcoming you to the 52nd Annual Convention of the Auxiliary to the Medical Association of Georgia and wishing for each of you a pleasant stay in our historic city.

In addition to the meetings where thoughtful consideration will be given to the vital work of the Auxiliary, much has been planned for your enjoyment. There will be a tour of downtown homes, browsing for that special purchase in charming antique shops, and a tennis tournament for those athletically inclined.

Make your plans now to accept our invitation to bask in the warm hospitality of Middle Georgia. Each of us looks forward to this opportunity for renewing old friendships and making new ones.

Mrs. J. G. Etheridge
President
Bibb County Medical Auxiliary

1977 Auxiliary Annual Convention Schedule

THURSDAY, APRIL 21

2:00-5:00 p.m.	Registration and Information Grand Foyer
2:00-5:00 p.m.	Hospitality and Exhibits Elm Room
3:00-4:00 p.m.	Pre-Convention Executive Board Meeting Mulberry Room
4:00-5:00 p.m.	Orientation 1977-78 Mulberry Room
6:30-7:30 p.m.	Reception for 1976-77 Executive Board Walnut and Cherry Rooms

FRIDAY, APRIL 22

8:30 a.m.-5:00 p.m.	Registration and Information Grand Foyer
8:30 a.m.-5:00 p.m.	Hospitality and Exhibits Elm Room
9:00-10:00 a.m.	MAG General Session Macon Ballroom
	Auxiliary President's Address
	Introduction of Guests
10:30 a.m.-12:00 noon	First General Session Walnut and Cherry Rooms
	Guest Speaker
	Memorial Service
1:00-2:00 p.m.	Luncheon Idle Hour Country Club

SATURDAY, APRIL 23

8:30 a.m.-12:00 noon	Registration and Information Grand Foyer
8:30 a.m.-12:00 noon	Hospitality and Exhibits Elm Room
8:00-9:00 a.m.	Past Presidents' Breakfast Mulberry Room
9:00-10:15 a.m.	Second General Session Walnut and Cherry Rooms
	Awards
	Installation of Officers
10:15-10:30 a.m.	Post-Convention Executive Board Meeting Walnut and Cherry Rooms
10:30 a.m.-12:00 noon	Annual GaMPAC Brunch (Tentative) Macon Ballroom
6:30-7:30 p.m.	MAG President's Reception Macon Ballroom

MEDICAL ASSOCIATION OF GEORGIA 123rd ANNUAL SESSION

April 22, 23, 24, 1977

MACON, GEORGIA

HOTEL RESERVATION INFORMATION

1. The MACON HILTON HOTEL has been designated as the Headquarters Hotel for MAG and the Auxiliary to MAG.
2. Association Officers, Councilors and Delegates will receive special housing forms from the Headquarters office, Auxiliary Officers and Executive Board will also receive special Housing Forms from the Auxiliary Secretary. All other interested members should utilize the housing form below.
3. Reservations will be accepted on a first come first served basis, after those categories listed above have been accommodated. When all rooms at the Macon Hilton have been reserved the Macon Hilton will automatically refer additional reservation requests to the Ramada Inn located at 2400 Riverside Drive, Macon 31204.
4. Make your reservations early. Unreserved room blocks will be released on March 25.
5. Except for those categories listed above, please utilize the form below and mail directly to the Macon Hilton.

MEDICAL ASSOCIATION OF GEORGIA

April 22-24, 1977

Please reserve the accommodations circled below in my name for arrival:

..... (Date), at ..... (Time) a.m. p.m., and departure ..... (Date) a.m. p.m.

DAILY ROOM RATES
FOR THE MACON HILTON HOTEL
P. O. Box 144
MACON, GA. 31202

Singles/one person	$18	$20	$22	$24
Doubles & Twins	$24	$26	$28	$30

Add $6 for each additional person

Reservations will be held until 6:00 p.m. unless guaranteed by one night's room rent accompanying this reservation.

Please mail a confirmation to:

Name .....

Address .....

Enjoy Your Stay In Macon

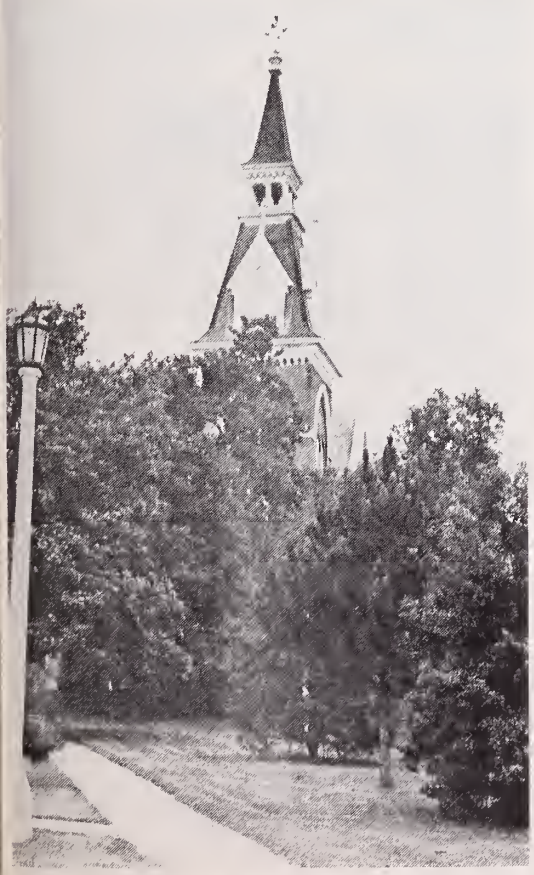


Ocmulgee National Monument

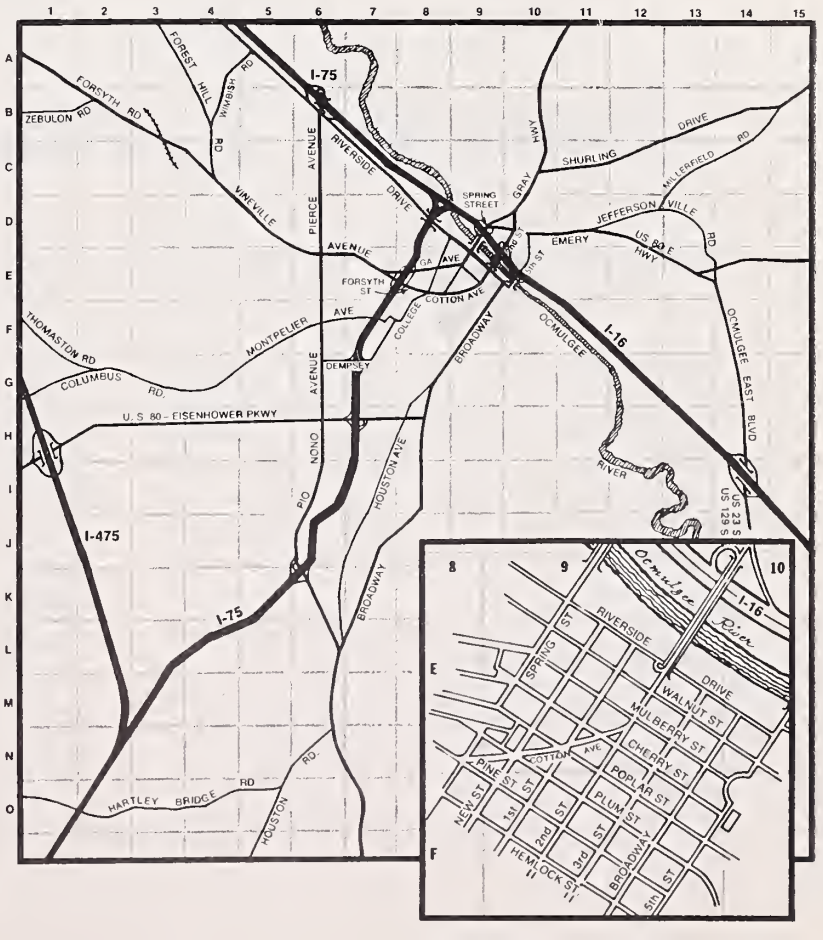
As denoted on our cover, Macon is a town rich in history. It was founded in 1823 on the site of prehistoric Indian tribe campgrounds and is the site of the **Ocmulgee National Monument,** Highway 80 East, the largest archaeological restoration of ancient Indian civilization to be found in the East. **Fort Hawkins,** Highway 80 East—a replica of the city's 1806 original fort—was built as a westward outpost for young America. Also of historic interest: the beautiful **Hay House,** 934 Georgia Ave., a 24-room Italian Renaissance mansion built in the 1850's; the **Sidney Lanier Cottage,** 935 High St.—the romantic birthplace of the South's beloved poet and headquarters of the Middle Georgia Historical Society; **Cannonball House,** 856 Mulberry St., built in 1853 and struck by a cannonball during Federal attack on Macon in 1864.

Macon is also an educational center, home of **Mercer University,** founded in 1833, and **Wesleyan College—**the world's first chartered college to grant degrees to women. Other attractions of interest to visitors include: the **Mark Smith Planetarium,** 4182 Forsyth Rd., at the **Macon Museum of Arts and Sciences,** the second largest planetarium in the Southeast; **Tobesofkee Recreation Area,** I-475 By-pass at Thomaston Road Interchange, 35 miles of lake shoreline; the **Grand Opera House,** 651 Mulberry St., a breath-takingly beautiful restoration of an old opera house. The Museum of Arts and Sciences will be open Thursday through Saturday, 9 a.m.-5 p.m., Friday 7:30-9:30 p.m. and Sunday 2-5 p.m. A Planetarium program will be presented Friday at 8 p.m. and the Nature Center is open during Museum hours, except Friday night, featuring environmental exhibits pertaining to plants and animals of Middle Georgia.

Old South charm intertwines with present day living in Macon, where you'll find small-town coziness and uptown tastes. For suggested restaurants in the area, please turn the page.



Steeple over Mercer University



Enjoy Your Stay In Macon

Welcome

I WOULD LIKE to take this opportunity to welcome you and your family to Middle Georgia for the MAG Annual Session, April 22-24, 1977.

You will find Macon a pretty and friendly city with much to offer for both business and pleasure. Macon has many beautiful anti-bellum homes and good restaurants, golf, tennis and water sports.

Though, as delegates, most of you will be busy with meetings, we will make every effort to make your entire family's visit to Macon an enjoyable and memorable occasion.



Hugh F. Smisson, Jr., M.D.
President
Bibb County Medical Society
879 Hemlock Street
Macon, Ga. 31201

Restaurants & Lounges in Macon

Our advance scouts have reported in. What follows is a list of some of the best restaurants and lounges in the Macon area, along with addresses and brief descriptions of what to expect. Telephone numbers are provided so you can call ahead for additional information.

Beall's 1860—315 College St. 19th Century decor. Prime Ribs of Beef plus seafood specialties and popular salad bar. 745-1780.

Beall's Lounge—in Beall's 1860. Historic atmosphere. 745-1780.

Beef Barron—Macon Hilton. Dramatic new feeling and touch of elegance. Sunday Buffet. 746-1461.

Block & Bottle Lounge—in Le Chateau Restaurant. Plush setting. 746-6185.

Cag's Open Hearth—4330 Forsyth Rd. Cheerful, cozy atmosphere. Specialties are seafood, Italian fare and steaks. 745-2881.

Green Jacket—240 2nd St. Superb steak, prime ribs. 743-5808.

Le Bistro—556 Mulberry St. Superb French cuisine. 745-8624.

Le Chateau Great Steaks—2460 Riverside Dr. Steaks, prime ribs, lobster and salad bar with 21 ingredients. 746-6185.

Sheraton Lounge—Sheraton Motor Inn, 2737 Sheraton Dr. Entertainment nightly. 745-8521.

Silver Dollar Lounge—Macon Hilton. Western atmosphere. 746-1461.

JOURNAL
of the medical association of
georgia

Three Causes of Syncope of One Patient, Detected by Holter Monitoring

LAURENCE LESSER, M.D. *and* NANETTE K. WENGER, M.D., *Atlanta**

SYNCOPE IS A COMMON symptom. It may result from a number of mechanisms involving control of peripheral arteriolar tone, localized cerebrovascular obstruction, or diminution of the cardiac output.[4, 5, 10] At times, it may be difficult to distinguish true syncope from a seizure disorder, hyperventilation or hysteria. Both trivial and life-threatening disorders may cause syncope. Because each entity carries unique implications for prognosis and therapy, the discovery of the etiology of syncope is of the highest priority. The ambulatory electrocardiogram has proved useful in evaluating rhythm disorders in patients with syncope. This case report illustrates its value in a patient with recurrent syncope of differing etiology.

The ambulatory electrocardiogram has proved useful in evaluating rhythm disorders in patients with syncope.

Case Report

S.H. is a 65-year-old woman who first experienced the transient loss of consciousness in September, 1969, while working at a sewing machine. The syncope was unassociated with coughing, head-turning, palpitations or chest pain. An initial ECG demonstrated no dysrhythmia or conduction abnormality. However, an ambulatory ECG revealed periods of second degree AV block with the ventricular rate falling to 35 per minute (Figure 1). This corresponded to periods of lightheadedness, as recorded in the patient log. A permanent transvenous pacemaker was inserted, and the patient became asymptomatic.

After an elective battery replacement in December 1971, syncope recurred in February 1972. A routine ECG failed to reveal any abnormality of pacemaker function, but intermittent pacemaker failure was detected by Holter monitoring (Figure 2). Despite insertion of a new lead system, syncope recurred two months later. Pacemaker malfunction was initially suspected, but this time, ambulatory ECG monitoring demonstrated ventricular tachycardia coinciding with syncope (Figure 3). The addition of quinidine sulfate has been effective in controlling further episodes of syncope.

Discussion

Syncope is a symptom which is always distressing to the patient and frequently taxes the ingenuity and resources of the physician. The introduction of the ambulatory ECG by Holter in 1961[7] has provided the physician with a powerful tool in evaluating possible rhythm disorders as a cause of syncope.[1, 2, 3, 6] It is increasingly recognized that cardiac dysrhythmias may underline obscure cerebral and cardiac symptoms.[8, 9] The transient nature of many dysrhythmias severely limits the usefulness of the conventional twelve-lead ECG which records the patient's rhythm for approximately one minute. The Holter system permits prolonged monitoring, preferably in the patient's own surroundings.

Abstract

Our patient demonstrated the correlation of syncope with three dysrhythmias, second degree AV block with a slow ventricular response, pacemaker failure, and ventricular tachycardia. The identification of each rhythm disorder led to effective management.

* Department of Cardiology, Emory University School of Medicine and the Cardiac Clinics, Grady Memorial Hospital, 69 Butler St., S.E., Atlanta, Ga. 30303. Dr. Lesser is supported in part by NHIL Training Grant HE-05731.

REFERENCES

1. Aranaga, C., Weaver, M., Stalwen, W., et al: Eight-Hour Electrocardiogram: Technique and Clinical Application," *Brit Heart J.* 29: 345, 1967.
2. Bliefer, S. B., Blufer, D. J., Hansmann, D. R., Sheppard, J. J., and Karpman, H. L.: "Diagnosis of Occult Arrhythmias by Holter Electrocardiography," *Prog. Cardiovasc. Dis.* 16:569, 1974.
3. Corday, E., Bazika, V., Lang, T., Pappelbaum, S., Gold, H., and Bernstein, H.: "Detection of Phantom Arrhythmias and Evanescent Electrocardiographic Abnormalities," *J. Amer. Med. Assoc.* 193:417, 19 .
4. Ebert, R. V.: "Syncope," *Circulation* 27:1148, 1963.
5. Friedberg, C.: "Syncope," *Mod. Con. Cardiovasc. Dis.* 40:55, 1971.
6. Harrison, D. C., Fitzgerald, J. W., and Winkle, R. A.: "Ambulatory Electrocardiography for Diagnosis and Treatment of Cardiac Arrhythmias," *NEJM* 294:373, 1976.
7. Holter, N. J.: "New Methods for Heart Studies," *Science* 134:1214, 1961.
8. Tzivori, D., and Stern, S.: "Pacemaker Implantation Based on Ambulatory Electrocardiographic Monitoring in Patients with Cerebral Symptoms," *Chest* 67:274, 1975.
9. Walter, P. F., Reid, S. D., and Wenger, N. K.: "Transient Cerebral Ischemia Due to Arrhythmia," *Ann. Int. Med.* 72:471, 1970.
10. Wright, K. E., Jr., and McIntosh, H. D.: "Syncope: A Review of Pathophysiological Mechanisms," *Prog Cardiovasc. Dis.* 13:580, 1971.

FIG. 1

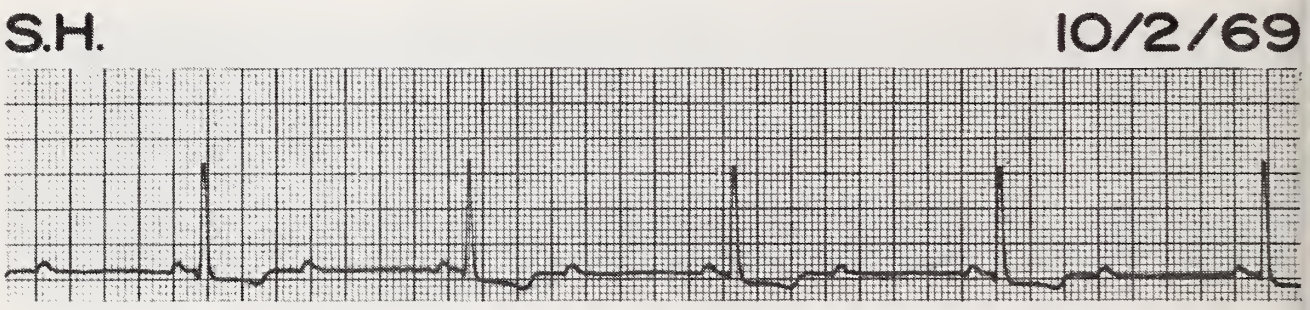


FIG. 2

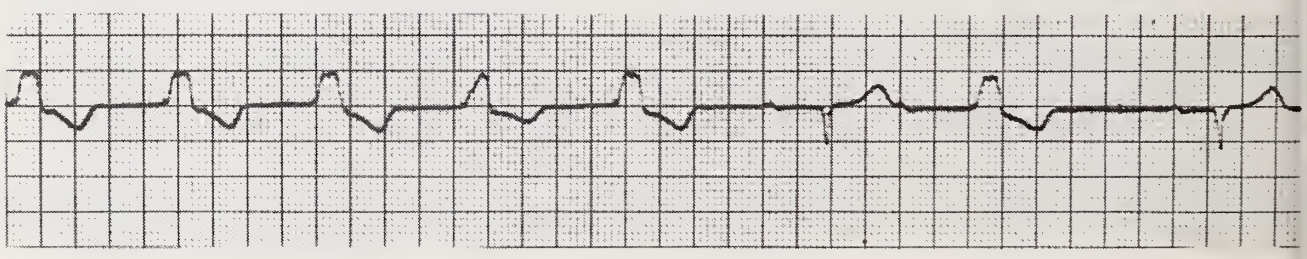
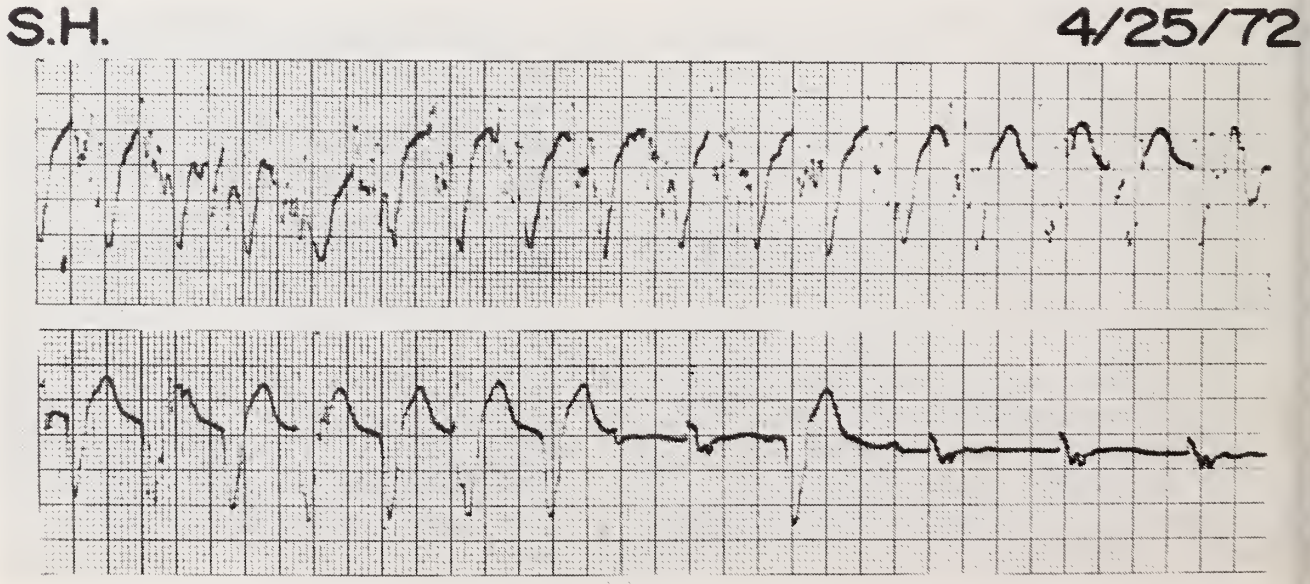


FIG. 3



Patients expect more than just a light and sound show when they need an ambulance. What are they getting in Georgia? An up-to-date report.

Pre-Hospital Emergency Care in Georgia: A Status Report

CHARLES B. MOSHER, M.D., *Atlanta**

OVER 100,000 PATIENTS call an ambulance each year in Georgia. County taxpayers shell out between 25 and 30 million dollars to keep the service available to them. What are your patients getting for it other than a good show with lights and siren?

In those areas of the state where the EMS system works near its maximum potential, the patient gets skilled emergency medical care under a physician's guidance within less than five minutes. And it's gotten to the stage in Georgia where this ideal is achieved in a large percentage of the cases—as frequently in small rural counties as in the cities.

Let's look at each of the elements in the statement above:

"skilled emergency medical care"—There are 2,678 full-time ambulance attendants in the state. Two thousand four hundred and ninety-eight (2,498) of them have completed the basic Emergency Medical Technician course (as recommended by AAOS plus an additional 43 hours) and passed the state certifying examination. These people are trained to quickly examine the patient, maintain the airway, stop hemorrhage, splint fractures, immobilize the spine, resuscitate patients in arrest and to extricate patients from crushed vehicles. To receive a state license, the ambulances must be equipped with needed equipment including O_2 tanks, sterile OB kits, traction splints, spine boards and burn dressings. Only 50 hearses remain among the total 467 emergency vehicles.

"under a physician's guidance"—The EMT present at the scene of an emergency is intended to function as the physician's hands, but occasionally his training needs to be augmented by a physician's consultation. Radio contact is essential for this.

As of this date, *all* licensed ambulances have radios (this is true in only five other states) and radios are required in all hospital emergency rooms. So Georgia is one of few states where the physician at the hospital emergency department can *always* speak to the EMT with his patient out in the field.

In the rural areas where an M.D. isn't always available in the emergency department, some doctors carry walkie-talkies, others depend on the nurse on duty to call for orders which are then relayed by radio. Moreover, there are now enough emergency departments with 24-hour physician coverage to allow EMT-to-physician conversation, even three or four counties away.

"within less than five minutes"—Analysis of patient records for the first quarter of 1976 showed the following statewide statistics:

response time to location:	0-5 minutes	51.9% cases
	6-10	21.9%
	11-15	9.0%

These outstanding response times are understandable given all but eight counties have ambulance services within their borders.

So that's the basic level emergency medical care program available in Georgia. A number of towns and counties have expanded these capabilities to include advance life support (ALS). This means the

* Medical Director, Emergency Health Section, Georgia Department of Human Resources, 618 Ponce de Leon Ave., N.E., Atlanta, Ga. 30308.

basic services mentioned above plus:

—starting IV fluids
—limited drug therapy
—defibrillation
—intubation

Heavy physician involvement is the key in an ALS program. EMT's need additional training to the level of Cardiac Technician or Advanced EMT and the training must be done by physicians and nurses in the larger hospitals. Moreover, radio contact is a must here since it is interpreted as illegal for Cardiac Technicians and Advanced EMT's to utilize these advanced skills on a standing order basis at this time.

Such systems are operating in Atlanta, Columbus, Athens, Savannah, Brunswick, Waycross, Albany and a number of counties adjacent to these cities.

How well are patients handled? The most valuable tool to gauge this is the physicians' or nurses' assessment at the emergency department. Additionally, by analyzing ambulance trip report forms from the first quarter of 1976 we get some objective information:

Only 1.3 percent of the patients died *after* the ambulance was on the scene.

Sixty-one percent of patients received some care other than just transportation to the hospital (more frequently oxygen, but including splinting, cardiac monitoring and emergency childbirth).

Thirty-four percent of all auto accident victims were treated with hemorrhage control, but only 4 percent received an IV.

Fifty-five percent of all cardiac cases received O_2.

Twelve percent of all cardiac cases required CPR, but only 2 percent were defibrillated in the field. Fifteen percent (15 percent) had cardiac monitors attached.

It is well known that deaths from auto accidents have been decreasing since 1974. Many people thank the 55 m.p.h. limit for these, but some of us feel improved emergency medical services from ambulance care through hospital ICU care has also been a major influence.

We looked at four diseases which regularly are cared for by EMS and found decreases in mortality during 1975 for all four. While we should wait until 1976 statistics are in (another two or three months) to make loud claims, I feel that improved patient care by EMTs, emergency nurses and emergency physicians is the *only* factor which could have affected all four diseases.

Year	*Ischemic Heart Disease*	*Auto Accidents*	*Other Accidents*	*Homicide*
1972	12,699	1,885	1,512	953
1973	12,854	1,847	1,657	985
1974	12,900	1,570	1,526	1,024
1975	12,196	1,411	1,451	871
1976	—	1,281*	—	—

* Provisional.

If, indeed, EMS is a major factor in the lower number of deaths in all four categories, the 1976 statistics should be as low or lower than those for 1975. We'll watch and see. But we still know there are many lives being saved in Georgia by the EMS system.

In summary, Georgians are provided a basic life support (BLS) system in the pre-hospital phase that, by many parameters, is among the best in the country. It is prompt, training of paramedical personnel is above average, and there is a radio system nearly 100 percent complete.

The greatest deficiencies in care at the scene will be corrected as ALS systems proliferate under close physician supervision (IV's for traumatic shock, defibrillation and drugs for cardiac arrest). The key is *active physician involvement.* More physicians need to exercise their rightful role in control of the system through:

—training of basic EMT's in vocational schools.
—utilization of the radio to give orders (buy a walkie-talkie if necessary).
—evaluation of performance at the emergency department.
—in-service training as needed, and advanced training when you, the physician, are ready.

Patient care will improve as physician involvement grows. Remember that your patients are among the 100,000 who will call for an ambulance this year.

(There are other very important aspects to the EMS program—particularly the growth of the emergency department nurses' specialty and the concept of hospital categorization. This article has dealt only with the *pre-hospital* phase of the EMS system).

WHAT ARE YOUR OBSERVATIONS

on pre-hospital care and emergency room care? What have you observed about Emergency Medical Technicians? Do you have ideas for how emergency services can be approved?

The EMS Newsletter would like to publish your 250-500-word articles on this subject. Submit any contributions you may have to:

EMS Newsletter Editor
Emergency Health Section
618 Ponce de Leon Ave.
Atlanta, Ga. 30308 Or Call (404) 894-5170

This mental health informational source is available to all health care personnel within the state.

The Addison M. Duval Library May Be Able to Help YOU

EDWARD J. D'ANNA, M.S.L.S., *Atlanta**

HAVE YOU EVER had a problem or question arise where you needed some additional information such as: information on alcoholism in the elderly; how is a particular type of therapy carried out and what effects can you look for it to produce; information on suicide in adolescents? All too often, because of the pressures of a busy practice and because the information is not immediately available, we let the question pass without finding the answer.

You now can have many of your mental health questions answered and some of your mental health information needs met by contacting the Addison M. Duval Library of the Georgia Mental Health Institute. Here a trained staff of mental health librarians and paraprofessionals work everyday providing mental health information of all kinds to the health care delivery personnel throughout Georgia. We will answer your mental health questions or refer you to a source of this information close to you.

History

"In 1965 the new Georgia Mental Health Institute was opened for operation. Its goals were: to educate, to seek, to treat in the areas of patient care, training and research in a broad range of mental health discipline areas. G.M.H.I. was to be Georgia's 'Manpower Factory' and was designed to overcome Georgia's greatest problem in the field of mental health at that time—a lack of trained and qualified personnel to staff the State's present and future mental health facilities. The Institute's professional staff was to consist not only of members of the Institute but members of the Emory University School of Medicine as well. A cooperative agreement with the Medical School was to provide the Institute's comprehensive teaching and research programs."[1]

The need for library service quickly became apparent, and in 1966 space was designated in the North Wing of the third floor of the Administration Building for a library facility to be established. This facility was to be administered, at that time, by a very active Library Committee and operated by one clerical staff member. The job of providing library materials sufficient to satisfy the needs of both professional and nonprofessional personnel with broad mental health interdisciplinary subject area interests was a large one. Soon another clerical position had to be added. Then in the late 1960's a half-time professional librarian was hired to direct the activities of the library. She worked approximately two years. The Institute's library committee then voted to hire a full-time, trained medical librarian for the position, and in January of 1972 the author became full-time director of all libraries on the campus of G.M.H.I.

In 1972, the G.M.H.I. library was named the Addison M. Duval Library for the man who had directed Georgia's Mental Health Program for the preceding nine years and who was retiring from a distinguished career in the field of mental health on July 31, 1972.

Overview of the Library

The Addison M. Duval Library of the Georgia Mental Health Institute provides complete library services to all staff and students of G.M.H.I., as well as to personnel in the Northeast Georgia Service Area served by the Institute and the health care delivery personnel throughout Georgia. The staff provides in-depth reference service, including compiling bibliographies and providing extensive literature searches on requested topics. Assistance is given to patrons in making the best use of the card catalog, the library's extensive reference collection, and other resources.

Special services include a current awareness and dissemination service. In this service, librarians scan all literature coming into the library and notify a large number of patrons about articles and information of interest to their own particular work. We provide computerized literature searching of the National Library of Medicine's data base called MEDLINE (Medical Literature Analysis and Retrieval System On-Line) in cooperation with the Calhoun Medical Library, Emory University. We also provide bibliographies and search services of the automated data base of the National Clearinghouse for Mental Health Information and other data bases of the Na-

* Director of Libraries, Georgia Mental Health Institute, 1256 Briarcliff Rd., N.E., Atlanta, Ga. 30306.

tional Institutes of Health covering alcohol, alcoholism, drugs and drug abuse.

The Addison M. Duval Library collection of approximately 15,000 books and over 4,000 bound journal volumes deals mostly with the areas of mental health. It also serves as a back-up resource for several other State of Georgia mental health libraries. The staff and resources of this Library are dedicated to providing all available information to help you, our potential patrons, perform your duties as expertly as possible and to make certain your information needs have been provided for.

The Director of Libraries of the Duval Library also acts as a library consultant to other health centers throughout Georgia and elsewhere. He provides help and advice in setting up library facilities and services and helps in gaining access to the available sources of information.

Services Provided

Several very useful services are provided to health care delivery people of Georgia by the Duval Library. These include an orientation program which is scheduled bimonthly and is held for new employees of the Institute, its affiliated institutions, and other interested individuals. Discussions of the various library services and basic library sources are presented. Individual library tours may be arranged on request. Anyone wishing to visit the Duval Library should contact the staff to make an appointment.

Bibliographies

Bibliographies on various subjects are compiled and updated regularly by the library staff. The topics cover a wide range of subject and discipline areas. Copies may be obtained from the Library. As a health care professional, you may also request a specific bibliography or literature search to be compiled on a specific subject tailored to your individual needs. Please allow adequate time for its preparation, as a large number of sources must be searched to obtain comprehensive coverage of the literature.

Automated Literature Searches

The staff can also help to formulate requests for computerized bibliographies which are available through the Calhoun Medical Library of Emory University, covering the literature for the past three years. There is a cost for this service which is paid directly to Emory University. Automated MEDLINE Searches are most helpful in obtaining information on a combination of two or more specific subjects; for example, schizophrenia in geriatric patients.

Annotated, computerized bibliographies are available through the National Clearinghouse for Mental Health Information of the National Institute of Mental Health in Rockville, Maryland. Bibliographies can also be obtained from National Institutes of Health Data Bases in drug and alcohol abuse. The searches will take three weeks or one month to obtain.

Photocopy Service

Photocopies of articles listed in the bibliographies prepared for you may be obtained from us at a small per-page fee.

Current Awareness Service

You may also request the library staff to be on the lookout for information as it appears in the newest incoming literature. The staff will make a note of your request and, as the new literature is received and is scanned. anything which is found on the requested topic will be called to your attention.

Acquisitions List

Every two months the library compiles a list of the new books received. If you wish to receive this list, please contact the Director of Libraries. Copies are also available in the Library. If there is a title of a work which you wish to have ordered for the Library, please contact us and whenever possible we will be happy to order it. Your suggestions will be greatly appreciated and will help strengthen our collection.

Circulation

Books and journals may be checked out of the Addison M. Duval Library by both State of Georgia staff and other affiliated persons and mental health personnel. Health care delivery personnel not affiliated in any way with the Institute or the State of Georgia may check out materials by making a small deposit to the Library which is refundable. This accords such borrowers the same privileges as Institute and State of Georgia employees.

Thus you have had an overview of one of the most extensive mental health libraries in the country located right here in Georgia. The Addison M. Duval Library contains a fine collection of materials on a broad range of mental health topics. It is here to help you, the health care delivery personnel of Georgia. We look forward to hearing from you and serving your information needs. Please contact us by phone at 404/894-5663, by mail or in person at the Addison M. Duval Library, Georgia Mental Health Institute, 1256 Briarcliff Road, N.E., Atlanta, Georgia 30306.

REFERENCE

1. "The New Georgia Mental Health Institute," *JMAG* 54:369-370 (Nov.) 1965.

Delineation of Fees According to Geographical Areas

AT THE 1976 House of Delegates Meeting of the Medical Association of Georgia, the delegation to the AMA was instructed to work for correction of the discriminatory fee allowances under Medicare and Medicaid based on geographical areas. Physicians in the small cities and in the rural areas were unable to obtain an equitable payment under this policy as compared to their colleagues in the large metropolitan areas.

As instructed by the House of Delegates, the Georgia delegation introduced a resolution at the AMA meeting in Dallas in the summer of 1976, pointing out the inequities of the present fee policy and asking the AMA to work toward giving relief to the rural physician. Senator Talmadge was also made aware of the problem, and last year included a provision in the Talmadge Bill for reform of Medicare and Medicaid to subsidize the rural physician to at least parity with his urban counterparts.

The AMA did two things: (1) it prevailed upon Senator Talmadge to remove the portion of the bill which would have improved the discriminatory policy, because of the fear that the "usual-customary-reasonable" principle of reimbursement might be compromised; (2) it referred Georgia's resolution to the Council on Medical Services for further study.

At the clinical session of the AMA in December 1976, the Reference Committee considering this matter, after hearing testimony and reviewing the report from the Council on Medical Services, made the following recommendations to the AMA House of Delegates:

(1) Continue to emphasize the usual and customary or reasonable charges as the basis for physician payment.

(2) Point out to physicians, especially those who are underpaid, that they should bill their appropriate fees for services, even if the payors reduce the amount of the final payment.

(3) Ask the American Medical Association to redouble its efforts to seek amendment of the Medicare law as it pertains to reimbursement for physician services and rescission of the "economic index" regulation, using all available legal means.

Georgia's delegation felt that, again, these recommendations really did not meet the problem and would never allow the rural physician to improve his relative fee position. It offered an amendment by addition, adding a fourth recommendation as follows:

(4) Since division of states into geographical areas for payment purposes under Medicare results generally in lower fees for rural physicians, and since lower fees tend to produce a negative incentive to physicians to locate in rural and thinly populated areas, the AMA should make every effort to remove the statutory and regulatory requirements for delineation of fees according to geographical areas.

In the debate on the floor of the House of Delegates the following points were made. The AMA has committed itself to the principle of providing rea-

sonable access to care for all citizens. The geographical maldistribution of physicians makes this an impossibility now. In Georgia, the allowable fees under Medicare for the rural physician are about 35 percent less than for a physician practicing in the city with equal training providing a similar service. This income differential is a significant deterrent to the young physician in choosing a rural location in which to practice. Eliminating discriminatory fee polcies would not answer all of the reasons for the geographical maldistribution of physicians, but it certainly would be a good step in the right direction. To effectuate a legislative change, initiative and active support by the AMA is mandatory.

Since adjustment of fees is determined by the existing U-C-R base there is no way the rural physician can ever make progress toward equity with his urban colleagues.

Another facet of the situation has received very little attention. In the urban hospital where there are resident physicians, emergency room physicians and various allied health assistants, much of the time-consuming work (such as performance and recording of histories, physicals, discharge summaries, emergency care, management of minor problems occurring during the night, etc.) are performed by personnel paid by the hospital. This leaves the attending physician primarily with the less time-consuming decision-making responsibilities. The rural physician, on the other hand, who is allowed a smaller fee, not only provides the basic physician decision-making service, but also performs the other technical and administrative tasks provided by hospital-paid personnel in larger hospitals. The physician in the small hospital *actually* deserves a substantial supplementary fee for his additional work.

Perhaps the most telling argument, in addition to the adverse effect on the geographical distribution of physicians, is the fact that the *patient*—not the physician—is the one who ultimately absorbs the difference in the payment allowances in many cases. A large number of physicians now do not take assignment of payment directly from Medicare, making the patient responsible for his entire fee. The rural patient pays the same tax, the same part B premium, and yet receives from the government a smaller proportion of his cost than does his neighbor across a county line in a metropolitan area. This is not only unfair but is very likely unconstitutional.

The matter poses somewhat of a dilemma for the strong advocates of the U-C-R concept, which actually protects the strong fee structure of certain of the higher paid physicians. But if our medical organizations are to maintain real credibility, and ultimately influence, they must face squarely issues which affect the availability and cost of care to all patients. At present the policy on fees certainly is one of these issues.

If the solution means that we have to compromise the U-C-R mechanism of fee determination for some sort of negotiated fee schedule, then perhaps the time might have arrived when this should be accepted in government programs where payment is made from public funds.

Charles D. Hollis, Jr., M.D.
P.O. Box 288
Albany, Ga. 31702

Rising Costs: Private Medicine's Vulnerable Spot

VARIOUS FORCES in Washington are jumping with glee at the thought that they have found the Achilles' heel at which to attack private medicine: rising costs.

If you recall your Homer, the heel was the one part of the body in which the Greek hero was vulnerable.

No longer can Washington accuse physicians of being 50,000 short in numbers. It cannot gainsay the peerless competence of American medicine. It cannot deny what the polls show: that most Americans are satisfied with the quality and availability of their care.

But rising costs—sensationalized by charges of Medicaid fraud on the part of a tiny minority of doctors—are being exploited as an excuse for an all-out move against our profession and its freedom.

Rate setting for medical services has been suggested by the Democratic platform and by Jimmy Carter. A move to make it mandatory in all states is likely to be made when the Health Planning Act comes up for extension in 1977—provided that law survives the joint suit of North Carolina and the AMA.

Yet, on the cost issue too, we physicians are generally invulnerable in fact, contrary to the thinking of some politicians. The climb in costs is largely due to impersonal factors that far transcend the personal ability of health-care providers to control them.

These factors include the growth and expansion of clinical competence and technology, the growth of health insurance and its incentives to better care, the relentless surge in professional-liability premiums. They also include greater longevity (and thus a greater incidence of chronic illness), steady inflation, and the network of administrative and procedural expenses engendered by federal involvement in care.

Further aggravating the cost problem is the absence of any quantitative limit on what medicine is supposed to do with its technology, or expected to do. Sophisticated surgery that may stretch life by a few years is unavoidably expensive, and that expense has to be reckoned with if life is to be so stretched.

Obviously, the Topsy-like growth in the demand for, and capabilities of, medical care since World War II has caused overlaps, imbalances, and disarrangements—particularly at the institutional level—and these should be relieved by voluntary planning. The AMA's blue-ribbon National Commission on the Cost of Medical Care, representing many walks of life (including government), is seeking to place the cost problem in its true perspective, so that practical remedies can be offered.

But there is no valid reason for government to try playing the role of marksman Paris and shoot an arrow at private medicine's heel.

Let us bring the real facts of medical costs to our state and communities in every way we can. The people must know that if government tries to do the worst to us, we can no longer do the best for them.

Prepared by the AMA Public Affairs Division.

New Managing Editor for the Journal

IT WAS WITH much regret that the resignation of our Managing Editor, Miss Kathy Morse, was accepted in December. She left the *Journal* after four outstanding years of service to accept a position in the Information Office of Fulton County. We wish her much success in her new undertaking.

We have been fortunate to find a very well qualified person to become our new Managing Editor. She is Mrs. Sharon Smith, a native of Alabama and a graduate in Journalism from Georgia State University. She brings with her a wealth of experience in the editing and writing fields. We all look forward to working with her to produce a publication of which you may justly be proud.

Edgar A. Woody, Jr., M.D.
Editor

president's letter



Let Me Hear From You

So, 'tis the end of February, 1977. 'Tis interesting that to reach you in this issue, I'm composing on the 4th of January. Yet, in this February issue much is being written about April events for our Annual Session.

The worthiness of the MAG to keep us updated on current events seems apparent on the single count of the time schedule—in delivering the monthly Journal.

Let's speculate a bit—perhaps the most comments to date about MAG have been "dues increase" and "mandatory membership."

Let us hope that our dilemma with Medicaid has ebbed. The current director seems like a nice enough gentleman and he brings a good track record to the position.

Now for Part II of my questionnaire—

1. If you reduce the dues, who would you fire from staff?
   1) 2)
2. With dues reduction, which services should be curtailed?
   1)
   2)
   3)
3. Given the opportunity, what would be the first change you'd make in MAG?
4. What does MAG do for you personally?
5. Do you like best (a) seashore? (b) mountains?
6. Do you like best (a) water skiing? (b) snow skiing?
7. Who is Billie Griffin?
8. What year was the last reunion for your medical school graduation class you attended?

Sincerely,

Fleming Jolley

Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Report on Clinical Meeting of AMA

THE CLINICAL MEETING of the AMA was held in Philadelphia in December. The delegation was well represented by the delegates, alternates and officers of the Medical Association of Georgia. The entire delegation was active in reviewing all the 160 resolutions and reports submitted for consideration by the House. These were each evaluated prior to the opening of the House and at each of the reference committees Georgia representatives were in attendance to hear more details of the resolutions and reports. The delegates were then on the floor of the House of Delegates to vote on the recommendations of the reference committees as they came back to the House of Delegates. With each of the subsequently numbered items the source of this report or resolution is included so that should more details on a particular item be desired they may be obtained from the headquarters office.

1) Report E, Council of Medical Service, Designation of Primary Care Physician. This report as finally adopted included internists, ob/gyn specialists, family practitioners and pediatricians as the primary designated specialists, but felt that the first contact of the patient with whomever he selected could be designated as the primary care source.

2) Report K, Council of Medical Service, Physicians' Assistants. This was an interim report on the committee's surveillance of the allied health personnel. An ad hoc committee on physicians' assistants has been established which has been charged with the responsibility of continued surveillance of the performance of the PA's. They are also to consider the physician's supervision and reimbursement procedures related to PA's.

3) Report on PSRO. This was primarily a status report on the nationwide development of the PSRO program. It was pointed out that funding of the individual PSRO's is at a far more satisfactory level at the present time than previously. There are 203 PSRO areas which have been designated and in 1977 there will be 160 additional PSRO's together with 60 planning PSRO's. There will be 23 designated PSRO areas where no operational PSRO is present. This includes Georgia.

4) Report HH of the Board of Trustees and Resolution 2 concerning nationwide peer review for national corporations seeking to curtail their health care costs. The Georgia delegation is to present its suggestion that AMA act as an umbrella operational unit for nationwide peer review to the AMA Board of Trustees.

5) Council on Medical Services, Report A deals with the suggestion by various states that physicians participate only in those peer review programs sponsored by organized medicine. The CMS felt that this was an unworkable plan. The Georgia delegation will submit testimony to CMS on the plan that operates within our state.

6) Resolutions 11, 77 and 80 all concerned suggested legislation to allow the development and use of the relative value scale by physician organizations within the United States. As you know, the federal government is in the position of both opposing and supporting the use of relative value scales by organized medicine.

7) Resolution 48, Medicare Fee Profiles, which has been referred to the Council on Medical Service, incident to the Georgia House of Delegates report advising the removal of geographic boundaries within the state as a basis for Medicare reimbursement. This matter was reintroduced to the House, received favorable comment on the floor of the House of Delegates and was referred to the Council on Medical Service. The Georgia delegation will provide the CMS with additional background information as to the value of this amendment.

8) Resolution 18, Support for Home Hemodialysis. It was pointed out in this report that both the effectiveness measured in total duration of life as well as the economy of the home hemodialysis program which operates for approximately one-half the amount of the hospital hemodialysis center were so effective that the AMA should introduce legislation to encourage the use of home hemodialysis.

9) Resolution 74 was introduced to seek cost accountability of government health programs by legislative redress. This was adopted.

10) Report JJ of the Board of Trustees concerning indemnification of health care review teams in the event of civil litigation. The AMA has prepared a model bill for introduction in various state legislatures and will be reviewed by the Georgia Legislative Committee.

11) Resolution 43, Standards for Rural Hospitals. Legislation is to be introduced on a national level altering the requirements for small hospitals with regard to 1) personnel, 2) education of personnel and 3) the scope of services provided.

12) Income Tax Deductions for Medical Student Loans and Scholarships, Resolution 65. The Council on Legislation has already drawn such a bill and will introduce it into the next Congress which would relieve medical students of the responsibility of income tax on either loans or scholarship funds.

13) Report U of the Board of Trustees, Resolution 4 and 27 all concern AMA support for vigorous investigation and prosecution efforts by the Department of HEW where fraud was detected in federal health programs. The House of Delegates felt it extremely important to point out the great difference between fraud and abuse of the program. Whereas fraud was felt to be a knowing violation of the law, abuse of the regulations was felt to be a completely different matter.

14) Report II, Board of Trustees, and 6 resolutions concerning health service area legislation, P.L. 641. These were status reports and suggested action in resolutions. In view of the litigation currently being pursued by the AMA and the state of North Carolina, all of these matters were referred to the Board of Trustees for their consideration so as to not jeopardize the suit.

15) National Health Insurance, Report QQ of the Board and 6 resolutions. The AMA House of Delegates did not reject National Health Insurance or the reintroduction of H.R. 6222 as had been requested by many state societies. The vote in the House of Delegates was 181 to 57. As H.R. 6222 is reintroduced to the national Congress, however, suggestions for altera-

tions, modifications and improvements were to be offered by both the Board of Trustees and the Legislative Council. Your Georgia delegation will submit suggested alterations to these bodies including limitation of benefits to those in need, freedom of choice of physician and patient and optional assignment of benefits.

16) Report F of the Board of Trustees. This is a comprehensive report dealing with the relationship of physicians' offices to hospitals or hospital associated and controlled office buildings where the details of the benefits and liabilities to be found in such relationship are detailed and might well be considered by physicians in Georgia considering such moves.

17) Report EE of the Board of Trustees, the responsibility of state physicians with regard JCAH surveys. This report details the availability to individual states of the right to participate in JCAH surveys. The Medical Association of Georgia has a committee preparing a report for consideration in 1977 by MAG.

18) Board of Trustees Report V and Resolution 108A76 regarding JCAH standards concerning hospital staff by-laws. The AMA adopted the position that hospital staffs should have by-laws that protect the physician members of the staff and strongly advocated that state and county societies peruse the by-laws of the hospitals within their areas to be certain that this was accomplished. The Medical Association of Georgia is investigating the extent of this procedure.

19) Report D of the Council of Medical Service concerning nursing home visits by physicians. In this report it is pointed out that the AMA opposes the arbitrary indications for nursing home visits by physicians and would suggest instead that medical necessity determine the frequency of visits.

20) Resolution 53 and 76 concerning JCAH requirement that medical staff privileges be associated with periodic health evaluations. AMA supports the periodic evaluation of the physical and mental capabilities of staff but feels that this should be left up to the executive committee of the individual staff.

21) Judicial Council Report B on euthanasia and terminal illness. Though general sentiment for as few "pronouncements" as possible were voiced by many delegates, it was pointed out that there was a need for guidance in some states where legislative consideration was being given this issue. Judicial Council is to report back to the House of Delegates in 1977.

22) Resolution 45, generic substitution. A substitute adoption by the House of Delegates included opposition to indiscriminate substitution, a recommendation that physicians consider the cost of prescription items and that generic substitution could be accomplished by the physician if he so desired at this time.

23) Resolution 84 from the pathology section on the reliability of tests. This was accepted as a late resolution because of recent accusations by the Department of HEW and requested an AMA refutation of this report and a study of the problem. This concerns the accuracy of the various laboratories around the United States.

24) Response to a prior request to list the AMA contract with the U.S. government. These were listed, documented and the total amount of money involved pointed out to be about $3 million.

25) Report of the Board of Trustees on subsequent AMA meeting sites. With the deletion of Dallas from the scheduled meeting sites in 1982, it was pointed out that Atlanta might be considered for that slot.

26) Report 00 of the Board of Trustees, the budget. With considerable pride the Association pointed that with marked fiscal restraint, the expenses in 1976 were kept at the same level as 1974, allowing the increase in revenues to be placed in the liquid reserves. The Board and House have agreed that these liquid reserves should be planned to reach 60% of the yearly budget.

27) Resolutions 10 and 15 concerned a dues reduction for the first year of membership in AMA. This was not accepted but was referred back for additional study. It was pointed out that the MAG currently has a reduced dues structure for the first and last years of practice.

28) Report BB of the Board on membership polls. This was a direct result of the previous MAG resolution that in 1977 there will be polls of the entire membership of the AMA on such items as national health insurance, continuing medical education, privacy of data, HSA's, and peer review.

29) Resolution 47, AMA insurance program. It was voted by the House of Delegates to keep the AMA insurance program in force the policy holder must remain a member of AMA, and it was also approved that the spouse of the covered member could obtain insurance after the spouse's death.

30) Resolution 59, toll free telephone number for the AMA. This was turned down by the House, but the Board was instructed to continue their investigation of the problem. It was suggested that communications and better member service could be obtained with this number. This will necessitate the expenditure of about $50,000 a year. Your delegation would like to hear from you, the membership, on whether or not you would like to have such a convenience. As you know, we now have a WATS line for the Medical Association of Georgia whereby the members throughout the state can call into the headquarters office at no charge. This number is 800/282-0224.

31) Report H of the Board, malpractice. This report urges the state to keep up their legislative efforts on the development of malpractice laws within their state. It included an update on legislation as it exists around the country today. Georgia has been held up as a model state resulting in favorable malpractice insurance rates.

32) Resolution 85, limitation of liability. The state of Idaho passed legislation which sets limits on the liability of physicians in malpractice action. This is being contested in court and the House of Delegates directed the Board of Trustees to support this effort feeling that the results nationwide would be extremely beneficial for physicians throughout the country.

The chairman of the AMA delegation, Dr. Harrison Rogers, is to be nominated for the position of Vice Speaker of the AMA House of Delegates at the June meeting in San Francisco. The delegation requests that the MAG membership as a whole support this effort by the Georgia delegation to obtain better representation in the AMA House and on the Board of Trustees of AMA. This nomination will be made to the House of Delegates, and the AMA delegates from each state will vote on the candidates.

THE DELEGATION was pleased to sponsor two medical students to participate in the meeting. Miss Marietta Nelson from the Medical College of Georgia and Mr. Sidney Gottlieb from Emory University got their first tastes of organized medicine. Following are their observations about the experience.

Students Introduced to Organized Medicine

I WAS ASKED to write about my reactions to the December 4-8 AMA convention. First, I would like to thank all of the members of the MAG for making it possible for me to go.

I learned a lot at the convention about both the AMA and the medical profession. I have never been around physicians very much and, frankly, had always thought of the AMA as an organization for the protection of physicians' monetary interests. So I was pleasantly surprised by almost everything I saw and heard while in Philadelphia.

I was most impressed by the amount of work put in by the Georgia delegates, who began their morning meetings at 6:30. I appreciated not only being allowed to listen and learn at these meetings and reference committee meetings, but also being listened to. Both the organization of the AMA and the proceedings of the convention were bewildering at first, and seemed bulky and inefficient, but began to make sense after a couple of days, and appeared to work surprisingly well.

Going to the convention helped me more clearly define my own ideas about such topics as National Health Insurance, professional peer review, and what the role of the physician should be. I observed the rather selective news coverage and could better understand the reasons for the public's misconceptions about the AMA, but was still somewhat disturbed myself over some of the attitudes expressed. A few (but still, too many) doctors seemed interested only in what the AMA could do for them and not what the AMA could do for the health of the American public. Also, I found the attitude that medicine is just another business rather depressing. It was nice to learn that less than one third of the AMA budget is spent on lobbying and internal activities, but I wasn't completely convinced, for example, that "it is a basic AMA goal that quality care be available to every American" (quote from *AMA—Working for a Healthier America* booklet). Too, I wish there had been more resolutions dealing with such problems as the increasing use of nuclear power in the U.S. (and I was very disappointed in the one resolution which did deal with that specific issue).

One problem at the convention was not being able to be in more than one place at a time, since there were always interesting things going on at the Civic Center, where the scientific exhibits and lectures were, while there were meetings at the Sheraton. At various exhibits and lectures, I learned about subjects ranging from recognizing certain heart murmurs and better emergency care to how to set up a practice in a small town. One of the lectures on kidney physiology was the most immediately helpful, since something I learned there showed up on a Pathology test I had the day I got back to Augusta.

The student meetings were very useful. I gained information about financial aid and current health manpower legislation to share with fellow students back at MCG. Since the convention, I have talked with MCG faculty members about the student liability issue and plan to work with them on the problem this year.

Lastly, I enjoyed the convention tremendously. Everything was fun, from touring bicentennial Philadelphia one afternoon and comparing notes with students from other schools, to having delightful talks with practicing physicians. Some of my ideas were changed and others reinforced at the convention, but I left convinced of the importance of joining and working through the AMA to solve current medical problems.

Marietta Nelson
Medical College of Georgia

I WOULD LIKE to thank the Medical Association of Georgia for sponsoring my trip to Philadelphia for the AMA Clinical Convention.

I feel fortunate to have had this early opportunity to see organized medicine at work. While a student, it is easy to remain unaware and uninformed of the various political issues pertaining to the medical profession. I was therefore particularly enlightened to explore some of these issues in some depth. Especially interesting were the formal and informal discussions on National Health Insurance, concerning which I heard no two identical opinions.

Away from the Delegates meetings was the Scientific Exhibit, where I lost myself each afternoon. Here the elaborate audio-visual presentations kept me scurrying from booth to booth until closing.

Finally, I would like to thank the members of the Georgia Delegation and their wives for their generous warmth and hospitality, and for their open patronage of medical student involvement in the AMA. The frank exchange of ideas between practicing physicians and their student successors is of benefit to all, and I am thankful to have had this opportunity to be part of it.

Sid Gottlieb
Emory University School of Medicine

cancer page
cancer page
cancer page

The Changing Picture of Malignant Melanoma

WILLIAM J. PENDERGRAST, M.D., *Atlanta**

THERE IS GOOD NEWS and bad news. The good news first.

The cure rate of malignant melanoma improved dramatically in the first fifty years of this century. In 1907, W. S. Handley reported the terrible prognosis of melanoma and advocated a more aggressive radical surgical attack on the disease. Bloodgood reported 200 cases of surgically treated melanoma at the Johns Hopkins Hospital in 1922. There was only one 5-year survivor in the group. A. P. Stout, the chief of pathology at Columbia Presbyterian, reported in 1932 that he "has never come in contact personally with any case of malignant skin melanoma which has remained more than six years without evidence of metastases or local recurrence."

Lane reviewed the experience at Columbia Presbyterian in 1958 and reported a 34 percent 5-year survival in 117 patients with malignant melanoma.

Lay education has made a great difference in the number of early cases being seen. The fatalistic attitude that was expressed by the opinion "don't bother it until it bothers you" was responsible for much patient delay and death, particularly in the case of melanoma. Many people now come in for removal of moles at the first sign of growth or change, with a resulting improved cure rate.

Clark and Breslau have given the pathologist a method of staging by measuring the depth of invasion and thickness of the lesion. It is felt that melanomas classified as Clark's level II or as Breslau's less than 1 mm. thick probably do not require a prophylactic lymph node dissection. For more advanced disease, aggressive surgical attack is still required.

Now the bad news. The incidence of melanoma seems definitely to be on the increase. The rate of occurrence of melanoma in New York State increased from 1.54 per 10,000 in 1950 to 3.39 per 10,000 in 1971. A similar increase in the number of cases reported is found in Connecticut, as well as in Canada, England, Wales, Australia, and New Zealand. It might be suggested that the increased incidence may be an artifact of new criteria of pathological diagnosis, and that many of the lesions now being recorded would not have been called melanoma in the past. It is probably true that diagnostic criteria have been sharpened, but this should lead to an increasing number of early cases with an increasing cure rate.

Unfortunately, this does not seem to be happening. The age-adjusted mortality rates in Connecticut from 1963 to 1972 show a slightly rising mortality for both sexes. In Canada, the age-adjusted mortality rates for melanoma are known ac-

---

* 478 Peachtree St., N.E., Atlanta, Ga. 30308.

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

curately. There has been a 93 percent increase in mortality for males between 1951-55 and 1966-67, and a 107 percent increase in mortality rate for women between the same periods. Similar rates are suggested for England and Wales.

There is a recognized increased incidence of melanoma in fair-skinned people, particularly related to the extent of exposure to sunlight. We should advise all of our blond patients to protect their skin from over exposure, and to watch all moles carefully for change in color or growh. At the present time, early diagnosis and aggressive surgery offer the only hope for the cure of this disease.

ASK MEDICARE . . .

Q: Dr. Brown asks: "When a procedure is performed outside of my office, is it necessary to identify the place of service on the Request for Medicare Payment form?"

A: "Yes, *if you perform services* in any place other than your office or the patient's home, the name and address of that place must be given in item 13. This item also should contain the name and address of the *source of services* a physician obtains outside of his office. In addition, the place of service must be indicated in column 7B showing the appropriate code from the footnote at the bottom of the page."

Q: "How is a Medicare patient notified about the reimbursement made on assigned claims submitted by a doctor's office?"

A: "He receives an Explanation of Medicare Benefits accounting for the action taken on each of his claims. In case of assignment, the beneficiary (or his representative) receives a copy of the notice sent to the physician."

Q: "May I, as primary surgeon, bill for my assistant's charge on a Medicare-B claim?"

A: No, Medicare regulations no longer permit such reassignment of benefits. Unless an assistant surgeon is clearly an employee of the primary surgeon each physician should complete a separate Medicare claim.

Q: How should we handle the signature requirement when the patient is illiterate?

A: The beneficiary may sign the Request for Medicare Payment form with his mark (X). The mark must be witnessed by another person who must verify that the X is the patient's mark, sign his own name and address as witness, and indicate his relationship or title. The physician or a member of his staff may witness the patient's mark as long as the reason is given for the mark.

Q: "If the total charge is shown in item 9 of the Request for Medicare Payment form is it necessary to fill in item 10, (amount paid) and item 11, (any unpaid balance due)?"

A: "Yes, please. The completion of all three items is absolutely essential in the settlement of all assigned claims, and is helpful even on unassigned claims. Although this has been a Program requirement, we recently have been asked by S.S.A. to follow it more closely. In order to avoid telephone inquiries and processing delays your cooperation is solicited.

Outlined below is a detailed explanation.

Item 9—Total charges—Please do not include previous balances in the total.

Item 10—Amount paid—If the patient has made partial payment for *services being billed,* show the amount. If not, enter zeros.

Item 11—Any unpaid balance due—Indicate only the amount still unpaid *for services itemized on the bill.* If no balance remains, enter zeros."

Q: "Does item #5 on the Request for Medicare Payment form mean that Medicare will submit a claim for complementary benefits with private insurance companies?"

A: "No. The beneficiary must file the claim with his private insurance company after Medicare has processed the claim. Most companies require that a copy of the Explanation of Medicare Benefits (EOMB) be sent in with such a claim."

heart page
heart page
heart page

When It's Heart Attack Every Minute Counts

JOE M. TURNER, M.D., *Tifton**

The Georgia Heart Association's 1977 education message is "How It Feels to Have a Heart Attack" and what to do when it happens. More than 12,000 Georgians die each year from this problem—the number one killer. Most of these victims never reach a hospital, mainly because they do not recognize the warning signals and call for help fast enough. It is speculated that at least 2,000 lives a year could be saved if Georgians would learn to recognize the early warning signs and act rapidly when they strike.

It is the responsibility of the practicing physician in the community more than any other to see that the appropriate information is dispersed. With the ready assistance of our Heart Association as well as the local Department of Human Resources health facilities, the distribution of this information is not an impossible task. Perhaps the most effective means to date has been education, beginning in the lower levels of our public school classroom with children contacting the parents at home. In addition, appropriate advertising, talks to community service organizations and clubs and in-hospital and office education by physicians and/or their assistants, are means of conveying this important information.

The message is simply that if you feel an uncomfortable pressure, fullness, squeezing or pain in the center of the chest for more than 2 minutes, you could be having a heart attack. Severe pain, dizziness, fainting, sweating, nausea or shortness of breath may also occur. The average heart attack patient waits *three hours* before seeking help. DON'T WAIT, get help immediately. Call the emergency rescue service or, if you can get to a hospital faster by car, have someone drive you. Be prepared. Know the location of the hospital and keep emergency phone numbers handy.

In addition to the process of education, the early detection of coronary disease goes still further. More and more individuals are obtaining periodic physical examinations and more industries are requiring examinations for employment. Herein lies the best opportunity for patient education as well as examination. We, as

---

* Medical Vice President of the Georgia Heart Association. Dr. Turner's address is Tifton Medical Clinic, P.C., P.O. Box 947, 712 East 18th St., Tifton, Ga. 31794.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, care of the Georgia Heart Association. Broadview Plaza Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

physicians, being the first line of defense, must obtain careful histories regarding not only chest discomfort but risk factors that would predispose to this difficulty. These would include, of course, hypertension, smoking, working conditions and, perhaps most important, family history. It is safe to say that atypical pain in a 35-year-old male who does not smoke and has no family history of heart disease would be considered to have a much safer prognosis than a similar history in a 35-year-old male smoking two packs of cigarettes daily with a father and three brothers who had died from heart disease under 50 years of age. It is the latter situation where suspicion and action may many times divert disaster. The treadmill, with all its problems, is still a valuable adjunct in further evaluation of these suspected cases—progressing to coronary angiography if indicated, whereas only a few years ago our alternative was watchful waiting for more typical chest pain to develop or a trial on drug therapy.

In spite of the successes of surgery and modern drugs, we have still fallen short until the disease itself can be eliminated. The very fact that the incidence of A.S.H.D. has now decreased for the first time is encouraging that this is not an impossible goal, but while we wait we must still remember—be educated—be prepared—"when it's heart attack, every minute counts."

HEART BYPASS OPERATIONS TOP 1,000 MARK AT EMORY

Emory surgeons have performed over 1,000 heart bypass operations in the last three years. Five hundred such bypass operations were done in the last year, according to E. Garland Herndon, Jr., M.D., vice president for health affairs and director of the Woodruff Medical Center of Emory University.

Headed by Charles R. Hatcher, Jr., M.D., chief of thoracic and cardiovascular surgery, the Emory team performs bypass surgery at Emory University Hospital, Crawford W. Long Hospital, Grady Memorial Hospital, and the Atlanta Veterans Administration Hospital.

If coronary artery blockage is detected via appropriate tests, the bypass operation can often prevent a life-threatening heart attack. The surgery involves taking a vein from the leg and using it to replace an obstructed coronary artery.

Although its effectiveness in prolonging life was questioned during the early years of the procedure, the method is now widely accepted by many physicians as a means of adding years to a patient's life expectancy.

One enthusiastic advocate of bypass surgery in carefully selected patients is J. Willis Hurst, M.D., a world-renowned cardiologist and professor and chairman of the Department of Medicine at Emory.

"In the past, the operation was done for the relief of chest discomfort due to coronary atherosclerosis," said Dr. Hurst in an article prepared for the Woodruff Medical Center Report. "We now have evidence that certain selected patients will not only have their chest discomfort relieved 80 per cent of the time but they will live longer as a result of the operation."

Operative mortality at Emory affiliated hospitals for coronary bypass patients was 1.4 per cent in the last 350 cases. "This figure is remarkably low and is unsurpassed anywhere in the world," Dr. Hurst said.

legal page
legal page
legal page

Estate Planning Aspects of the Tax Reform Act of 1976

WILLIAM LINKOUS, JR. *and* ERIC P. NEUMAN, *Atlanta**

The Tax Reform Act of 1976 represents one of the broadest pieces of tax legislation in years. The Act was particularly wide-reaching in its effect on the area of trust, estate, gift, and retirement planning. The discussion that follows is intended to summarize the major changes in these areas.

The Tax Reform Act established a "unified" tax rate schedule applicable to the computation of estate and gift taxes for gifts made and estates of decedents dying on and after January 1, 1977. The new tax rate as applied to gifts, however, will take into account all pre-1977 taxable gifts. The estate tax is determined by applying the unified rate to total transfers made during life and at death, and then subtracting from that figure the taxes paid on lifetime transfers.

A new unified credit replaces the separate $30,000 exemption for gift tax purposes and the $60,000 specific exemption for estate tax purposes. The unified credit increases over a five-year period, beginning at $30,000 in 1977 and rising to $47,000 in 1981. The credit is equivalent to an exemption in 1977 of the first $120,000 of combined lifetime and deathtime taxable transfers. In 1981 the credit is equivalent to an exemption of $175,000 of such transfers. The new law retains the $3,000-per-donee annual exclusion ($6,000 with consenting spouse) for lifetime gifts.

For purposes of the tax applicable to estates of persons dying, beginning in 1977, the maximum allowable marital deduction is the greater of $250,000 or one-half of the adjusted gross estate (i.e., gross estate minus debts and expenses of administration). For decedents with an adjusted gross estate in excess of $500,000, the effective maximum marital deduction will therefore continue to be one-half of the adjusted gross estate. As to estates with an adjusted gross value of less than $500,000, the new law represents an increase in the allowable maximum marital deduction.

For purposes of the tax applicable to lifetime gifts to a spouse, beginning in 1977 an unlimited marital deduction is allowed for the first $100,000 of such transfers, but no marital deduction is allowed for the next $100,000 of such gifts. For all lifetime transfers to a spouse in excess of $200,000, the old law allowing a marital deduction of up to one-half of the value of such gifts applies. However, to the extent the gift tax marital deduction is claimed for amounts in excess of one-half of the value of property transferred to a spouse during life, the marital deduction allowable to the donor's estate for property passing to a surviving spouse at death is reduced.

The new law establishes an "orphan's" deduction for estate tax purposes. As

---

* Prepared at the request of The Medical Association of Georgia. Mr. William Linkous, Jr. is a partner and Mr. Eric P. Neuman is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

to persons dying, beginning in 1977, there may be deducted from the estate amounts which pass to children of the decedent who are under 21 years of age if the decedent left no surviving spouse and the child has no known surviving parent. The maximum deduction is $5,000 for each year the child is under 21 and applies to each child of the decedent, including adopted children (even though they may be survived by natural parents).

The Generation-Skipping Tax

In a major innovation, the Tax Reform Act creates a "generation-skipping" tax. Under this section a tax is imposed where a trust (or similar arrangement such as a life estate) is created either during lifetime or by will and benefits are split between beneficiaries who are in two or more generations younger than the donor or the testator. The tax is imposed upon the distribution of trust property (principal—not income) to a beneficiary in a generation lower than the first generation after the donor or testator in which there are beneficiaries of the trust. For example, where a trust is established to provide income for the life of a child of the donor with remainder to the grandchildren of the donor, the generation-skipping tax would be incurred upon the death of the child. The tax would also apply to distributions of principal from the trust to the grandchildren while the child is still alive.

The generation-skipping tax is based upon the estate tax rates which would apply if the property passing to the second lower generation were included in the estate of the intervening generation beneficiary. There is, however, an exemption of $250,000 for aggregate benefits passing to all of the children of *each* child of the donor or testator, although this exclusion does not apply to benefits passing to any other class of beneficiaries. The tax does not apply where property passes outright to or is held strictly for beneficiaries in a generation lower than the first generation after the donor or testator.

The generation-skipping tax applies to transfers which occur after April 30, 1976. The tax does not apply to transfers pursuant to a trust which was irrevocable on April 30, 1976, except to the extent that a transfer was made from property added to the trust after that date. The tax also does not apply to transfers under revocable trusts or wills in existence on April 30, 1976, if the donor or testator dies before January 1, 1982, without having amended the instrument since April 30, 1976, in a way which increases the generation-skipping amount.

As to transfers made prior to January 1, 1977, the law formerly presumed that gifts made within three years of death were made in contemplation of death and their value was included in the donor-decedent's gross estate for estate tax purposes, but this presumption was rebuttable. Any gift tax paid on such transfers was not included in the estate for estate tax purposes even if the gift was in contemplation of death. The new law provides that the value of property transferred after January 1, 1977, and within three years of death is unconditionally included in the gross estate. Further, the amount of tax paid on such gifts is also included in the gross estate for tax purposes, although credit is given against the estate tax for the amount of the gift tax paid.

On transfers of stock in trust after June 22, 1976, the value of such stock will be included in the donor's gross estate for tax purposes where the donor retained the right to vote the stock. Transfers into trust after May 21, 1976, of assets which have unrealized appreciation on the date of transfer will result in tax at rates applicable to the transferor if the assets are sold within two years of the date of transfer, except in the case of certain charitable remainder trusts and property acquired by a trust from a decedent.

Use of Real Property

In the case of decedents dying, beginning in 1977, the representative of the decedent's estate may elect to value real property included in the decedent's estate

which is devoted to farming or other closely held business at its value for such use rather than at its value based on its "highest and best" use. Highly technical and complex rules govern the qualification of property for this valuation method and the specific method of calculating that valuation. This rule may not be used to reduce the value of the gross estate by more than $500,000. The tax benefits of this reduced valuation are recaptured if, within 15 years after the decedent's death, the property is transferred to non-family members or ceases to be used for farming or other closely held business purpose.

The basis of property acquired from a decedent who dies, beginning in 1977, will be the adjusted basis of the property in the hands of the decedent increased by the federal and state estate taxes attributable to appreciation in the value of the property. This is known as the "carryover basis" rule. As to assets which the decedent owned on December 31, 1976, for purposes of determining gain (but not loss), the law provides a "fresh start" and the property takes a basis equal to its value on that date, if greater than the decedent's adjusted basis. Prior to the passage of the new law, property inherited from a decedent acquired a new basis equal to its value in the decedent's estate for estate tax purposes. In the case of securities, the valuation on December 31, 1976, according to market quotations, is the value assigned. For other carryover basis assets, the December 31, 1976, value is computed by a formula which assumes that appreciation accrued on a straight line basis from the date acquired by the decedent to the date of death.

The estate tax exclusion for death benefits received under a qualified pension or profit-sharing plan has been broadened to include individual retirement accounts and self-employed (HR-10) plans. But the exclusion is no longer available for benefits received as a lump sum. However, the law remains unchanged in that if the taxpayer elects a lump sum distribution, it may be treated as ordinary income and subject to 10-year income averaging. This election can be used to avoid the minimum tax on preference items, including capital gains.

The filing requirement for estate tax returns has been revised to conform with the new unified credit. Thus, estate tax returns will be required only when the value of the gross estate exceeds the exemption equivalent of the unified credit in the year of death. Henceforth a gift tax return must be filed for the first calendar quarter during which total cumulative taxable gifts made, during the year for which a return has not been made, exceed $25,000, and for any subsequent calendar quarters in which taxable gifts are made. If the total taxable gifts during a calendar year do not exceed $25,000, then only one return must be filed for the calendar year.

I've told this before . . . .

(Editor's note: The good doctor gets a taste of his own medicine in this real-life episode from Dr. McDaniel. Others wishing to contribute to this page should send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

A Retiree's Lunch

WHEN I RETIRED some years ago, I told my good wife that I did not choose to be underfoot, primarily because I had heard so many wives complain about the old man, retired, who hampered their activities and that he was just a plain damned nuisance hanging around the house all day.

Therefore, I said in no uncertain terms, you carry on with bridge parties, church goings on, sewing clubs and all other fascinating groups that keep you posted on divorces, weddings, engagements and all the other things so fascinating to wives of all ages and so necessary for their happiness and contentment.

And, bless her, she has done this after a fashion. In the beginning when she was going to be gone all day, she laid out or told me where my lunch was, but I kept talking about my independence. I could find my lunch, etc., and I might even cook something myself.

Today taught me a rather severe lesson. For 40 years, I have occasionally come into the home and something would be burning on the stove or in the oven and she would be upstairs trying to calm a child, fitting a dress on one of them, talking on the telephone, and I would speak in a loud voice about the house being on fire or make some other inane remark.

Today she left me at a little after 9:00 a.m.—I was still reading the paper. She gave me a peck of a kiss and said that she would be back at four or five o'clock, and told me where she would be for lunch—one of the girls' homes.

That was O.K. because I knew that there were the remains of a sort of beef goulash in the refrigerator which I dearly love. At 1:30 p.m. I got it out, put it in a pot, added some water, put a piece of bread in the oven, turned on the gas low and went upstairs to write a letter.

I put some time in the format of the letter and was thinking about the proper adjective to use about something, when suddenly there came upstairs a most terrible smell of burnt meat, onions and potatoes. I rushed downstairs and found everything smoking.

It took me a good hour to clean out the burnt pans, to say nothing of cooking more food. I opened all doors and turned up the heat.

When my wife came in, the first thing that she said as she hung up her coat was "has this house been on fire?"

J. G. McDaniel, M.D.
820 W. Wesley Rd., N.W.
Atlanta, Ga. 30327

the association
the association
the association

NEW MEMBERS

Altenau, Mark M., MAA—Act—Oto
25 Prescott St., NE, Suite 6404, Atlanta 30308

Berry, Neil C., Cobb—S—Or
Meddac, Ft. McPherson 30302

Bohan, Gunar N., DeKalb—Act—Ph
440 Winn Way, Decatur 30033

Brandau, A. Gordon, Jr., DeKalb—Act—I
2656 Regency Dr., W. Tucker 30084

Broun, Paul C., Jr., Sumter—Act—FP
1102 East Lamar St., Americus 31709

Claiborne, Thomas S., Jr., MAA—Act—I
35 Collier Rd., NW, Suite 650, Atlanta 30309

Clark, Eugene C., Dougherty—Act—I
420 4th Ave., Albany 31701

Cope, Douglas O., Ogeechee River—Act—Oph
127 N. Main St., Statesboro 30458

Coppage, William M., DeKalb—Act—Anes
755 Columbia Dr., Suite 615, Decatur 30030

Dehghanian, Javad, Chattahoochee—Act—Pd
2354 N. Main St., Snellville 30278

Doerr, James L., Troup—Act—Su
303 Smith St., LaGrange 30240

Domescik, Gerald, MAA—S—R
3200 Howell Mill Rd., NW, Atlanta 30327

Flanagan, Francis J., Laurens—Act
VA Center, Dublin 31021

Flynn, Gregory E., Cobb—Act—Oph
2550 Windy Hill Rd., Suite 303, Marietta 30067

Frist, Stephen, Clayton-Fayette—Act—Path
Clayton General Hospital, Riverdale 30274

Fuller, James W., Peach Belt—Act—Su
Robins AFB Hospital, Warner Robins 31903

Giesler, Garnett J., Jr., Troup—Act—Pul
303 Smith St., LaGrange 30240

Goetzinger, Robert T., MAA—Act—Oph
705 Juniper St., NE, Atlanta 30308

Godard, John E., Carroll-Douglas-Haralson—Act—Oph
Route 10, Box 258, Carrollton 30117

Gray, Otis L., Jr., Richmond—Act—FP
3623 J. Dewey Gray Circle, Augusta 30909

Greenway, Hubert T., Jr., Cobb—S
Naval Air Station Dispensary, Marietta 30060

Gronsbell, Mark D., Hall—A—P
N. Ga. Mental Health Center, Gainesville 30501

Guy, Ernest P., DeKalb—Act—Anes
1484 Indian Forest Court, Stone Mountain 30083

Guzman, Margarita, Habersham—Act—Su
Highway 441, Box 637, Demorest 30535

Hardison, Joseph E., MAA—S—I
VA Hospital, 1670 Clairmont Rd., Decatur 30033

Hunter, Stephen C., Muscogee—Act—Or
105 Physicians Building, Columbus 31901

Iskander, Karim N., Walker-Catoosa-Dade—Act—ObG
Tri-County Hospital, Ft. Oglethorpe 30742

Johnson, Ray L., MAA—Act—P
Doctors Building, Suite 914-A, Atlanta 30308

Kim, Sun-Hee, MAA—Act—Su
2351 Bolton Rd., NW, Atlanta 30318

King, Charles R., Glynn—Act—Or
3204 Shrine Rd., Brunswick 31520

Korsower, Allan J., Cobb—Act—Ns
2214 Dogwood Lane, NE, Atlanta 30345

Lang, William C., Jr., MAA—Act—R
3200 Howell Mill Rd., NW, Atlanta 30327

Leff, Stephen P., DeKalb—Act—Oph
2754 N. Decatur Rd., Decatur 30033

Lopez, Hector H., Clayton-Fayette—Act—I
33 SW Upper Riverdale Rd., Riverdale 30274

Maxey, Clarence O., DeKalb—Act—Anes
2701 N. Decatur Rd., Decatur 30033

McClellan, William M., Troup—Act—I
303 Smith St., LaGrange 30240

McClure, Charles G., Richmond—Act—N
1003 Chafee Ave., Augusta 30904

Mejia, Ivan, Cobb—Act—Anes
2540 Windy Hill Rd., NW, Atlanta 30327

Morley, Andy P., Jr., DeKalb—Act—FP
Decatur Clinic, 231 E. Ponce de Leon, Decatur 30030

Nixon, Daniel W., Richmond—Act—On
Medical College of Ga., Augusta 30904

Posner, Geoffrey M., MAA—Act—Oph
340 Boulevard, NE, Atlanta 30312

Purdy, Donald D., Bibb—Act—FP
784 Spring St., Macon 31201

Rankin, Fred M., Jr., Bibb—Act—Anes
Medical Center of Central Ga., Macon 31201

Ray, John W., MAA—Act—R
1170 Cleveland Ave., East Point 30344

Read, John M., MAA—Act—Pd
340 Boulevard, NE, Atlanta 30312

Remigailo, Richard V., Chattahoochee—Act—U
3412 McClure Bridge Rd., Duluth 30136

Roberts, John E., Cobb—Act—FP
1680 Mulkey Rd., Suite F, Austell 30001

Rodriguez, Francisco, Carroll-Douglas—Act—U
Groover Medical Building, Carrollton 30117

Sacra, John C., Richmond—Act—Em
1350 Walton Way, Augusta 30904

Shaw, Matthew C., Cobb—Act—Anes
1754 Cherokee St., Marietta 30060

Sheils, Wayne Chris, Muscogee—Act—R
P.O. Box 2787, Columbus 31902

Sherman, Jerald J., Cobb—Act—ObG
2550 Windy Hill Rd., Marietta 30067

Shewey, Lana L., Glynn—Act—I
2705 Wildwood Dr., Brunswick 31520

Spivey, Jimmy A., Peach Belt—Act—Or
124 Hospital Dr., Warner Robins 31093

Stanton, Paul E., Jr., MAA—Act—VS
315 Boulevard NE, Suite 500, Atlanta 30312

Stewart, Deanna B., Cobb—Act—Pd
652 Church St., Marietta 30060

Terry, William H., Bibb—Act—I
811 Orange Terrace, Macon 31201

Trager, Victor, Screven—Act—ObG
213 Mims Rd., Sylvania 30467

Tripp, John N., DeKalb—Act—FP
4330 LaVista Rd., Bldg. 11, Suite 21, Tucker 30084

Tucker, Thomas S., Colquitt—Act—I
1843 3rd St., Moultrie 31768

Turba, John E., Muscogee—Act—Or
105 Physicians Building, Columbus 31901

Weaver, Rose Ann Rigby, Oconee Valley—Act—I
172 N. Main St., Madison 30650

Wieland, William F., Cobb—Act—P
3995 S. Cobb Dr., Ridgeview Institute, Smyrna 30080

Wright, Stephen C., Cobb—Act—CHP
3188 Atlanta St., SE, Smyrna 30080

SOCIETIES

Dr. Fleming Jolley, President of MAG, and Rusty Kidd, Director of Legislative Activities, were the special guest speakers at the January meeting of the **Hall County Medical Society.** Dr. Jolley reported that HEW's Fraud Team, which was investigating Georgia physicians, returned to Washington without a single case to report. He also recommended that MAG have a more active role in the Board of Medical Examiners and that members support the Disabled Doctors Program. Mr. Kidd gave attendees a rundown of the legislation that would be considered when the General Assembly convened.

The **Muscogee County Medical Society** and its **Auxiliary** entertained the local legislative delegation and their wives at a dinner in January. In February, Dr. J. Rhodes Haverty was the speaker at the society's meeting. Next month, the society will meet jointly with the Columbus Lawyers Club to hear Dr. William S. Allerton, Director of the Division of Mental Health and Mental Retardation of the Georgia Department of Human Resources.

PERSONALS

First District

Cliff L. Cannon, Jr., M.D., has been named Chief of Staff for Memorial Medical Center for 1977. A Fellow of the American College of Surgeons, he has had his neurosurgical practice in Savannah for six years.

The American College of Radiology has awarded a Fellowship to **Gerald E. Caplan, M.D.,** of Savannah.

Edgar J. Filson, M.D., a Savannah radiologist, has been named Chief of Staff for Candler General Hospital. Serving with him will be **John M. Fillingim, M.D.,** Chief of Staff-Elect.

Fifth District

The American College of Cardiology has granted Fellowships to **Michael A. Chorches, M.D.** and **Charles W. Wickliffe, M.D.,** both of Atlanta.

Seventh District

The Medical Staff of Sam Howell Memorial Hospital has elected **Judy I. Orosz, M.D.** President of the Medical Staff for the coming year. A pediatrician, Dr. Orosz has been a member of the Medical Staff since July 1974.

Stephen C. May, Jr., M.D., of Kennesaw, was sworn in as President-Elect of the Georgia Academy of Family Physicians by Leslie Huffman, M.D., President of the American Academy of Family Physicians.

DEATHS

Virgil Lee Darby

Vidalia physician Virgil Lee Darby, 92, died January 4 in the Ware County Hospital, following an extended illness.

A native of Walton County, Dr. Darby moved to Vidalia with his parents in 1892. He began the practice of medicine before he was 21 years old.

Dr. Darby was a graduate of the University of Georgia Medical College in Augusta and the Baltimore, Maryland, School of Medicine. He served his internship in New Orleans at Charity Hospital.

Survivors include his wife, Ruth Hosch Darby; a daughter, Mrs. Miriam McDermid of Ft. Pierce, Fla.; a son, Dr. Lee H. Darby of New Smyrna Beach, Fla.; two sisters.

Bon M. Durham

Bon M. Durham of Americus died in December at the age of 60. A native of Dahlonega, he had been practicing medicine in Americus for 30 years.

Dr. Durham was a graduate of the University of Georgia and the Medical College of Georgia.

He was survived by his wife, Nina Fuller Durham; a daughter, Grace Durham of Americus; a sister.

Julius V. Pierotti

Atlanta physician Julius Vincent Pierotti, Sr., died January 17 at the age of 67.

Dr. Pierotti had long been associated with the Our Lady of Perpetual Help Cancer Home, providing medical services there on a volunteer basis. He was on the staff of the Crawford W. Long Memorial Hospital, St. Joseph Infirmary and South Fulton Hospital.

Survivors include his wife, Sara Harris Pierotti; a daughter, Mrs. Judy Melton; a son, J. Vincent Pierotti, Jr.; a sister.

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

BRIEF SUMMARY OF
PRESCRIBING INFORMATION
ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

One swallow does it



eliminates Pinworms and Roundworms with a single dose

■ **Single dose effectiveness against both pinworms and roundworms**—The only single-dose anthelmintic effective against pinworms *and* roundworms.

■ **Nonstaining**—to oral mucosa, stomach contents, stools, clothing or linen.

■ **Well tolerated**—the most frequently encountered adverse reactions are related to the gastrointestinal tract.

■ **Economical**—a single prescription will treat the whole family.

■ **Highly acceptable**—pleasant-tasting caramel flavor.

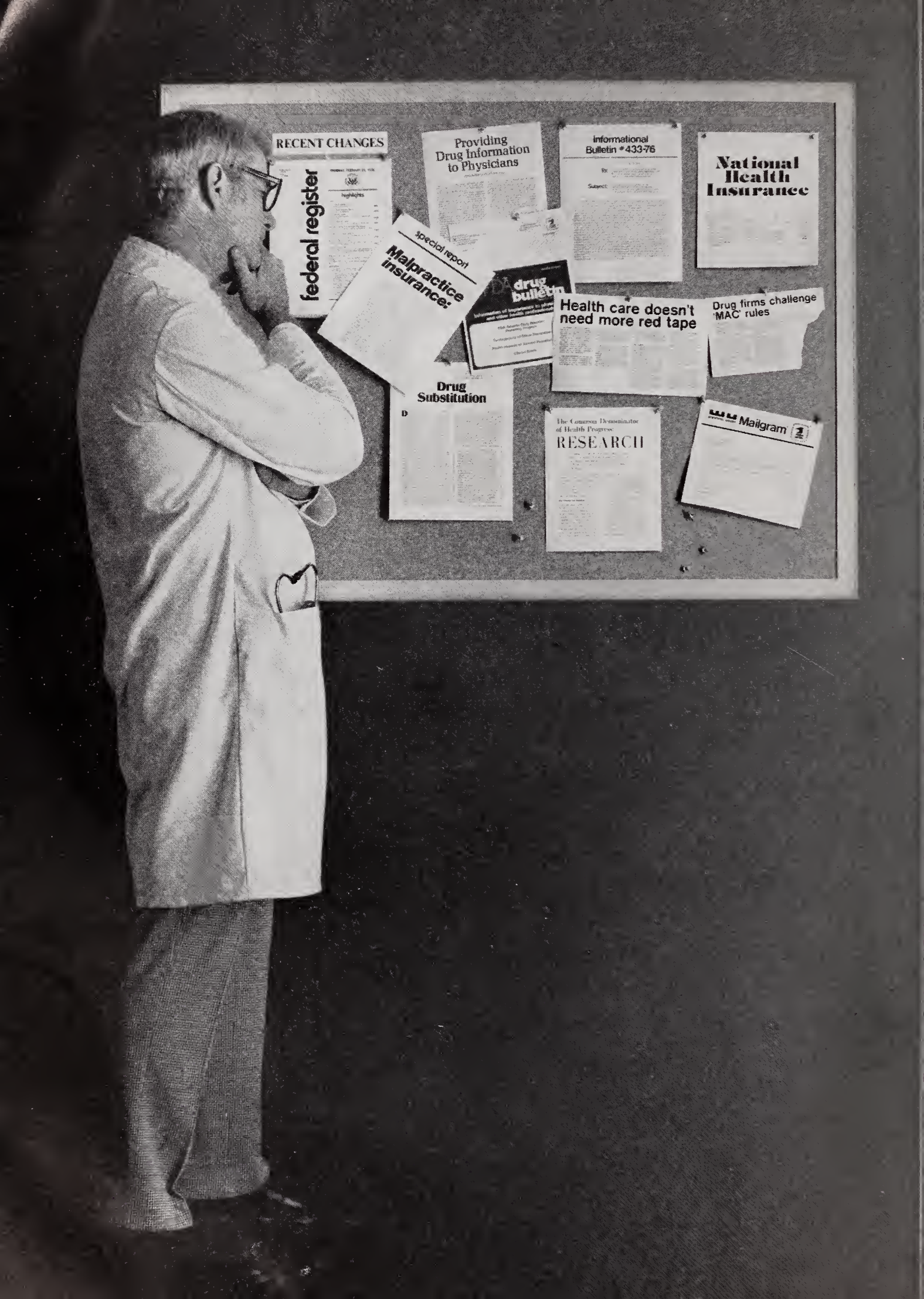
■ **Convenient**—just 1 tsp. for every 50 lbs. of body weight. May be taken without regard to meals or time of day.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Please see prescribing information on facing page. NSN 6505-00-148-6967

Antiminth® ORAL SUSPENSION

(pyrantel pamoate) equivalent to 50mg pyrantel/ml


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all nds of scrutiny. Your control over patient therapy is eing monitored, judged and occasionally abrogated, metimes by unknown third parties.

The worry is that in the wake of this focus, the relaonship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your on-generic prescriptions be filled with the precise prodcts you prescribe. But in the last five years, a dozen or ore State laws have been changed, permitting the pharacist in most cases to select a product of the same eneric drug to fill any prescription.

Ironically, this dilution of physician control has ken place against a background of growing evidence at purportedly equivalent drug products may be inuivalent, since neither present drug standards nor their forcement are optimal. In fact, the FDA itself says it s not enforced the same standards for hundreds of ollow-on" products that it had applied to the original DA approvals. Thus physician control over patient erapy is being eroded with a risk that patients may be posed to drugs of uncertain quality.

The major advertised claim for substitution is reduced escription prices for consumers. Yet no documentation any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's ug bill by setting price ceilings for drugs dispensed to edicare and Medicaid patients. Unless the prescriber rtifies on the prescription that a particular product is edically necessary, the Government intends to pay only r the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Opportunities for Continuing Medical Education

TREATMENT OF NEUROLOGIC DISORDERS

March 3-5, 1977
DeSoto Hilton Hotel, Savannah, Georgia
$125.00
Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30901 404/828-3967
Approved for 14 hours credit in Category 1 of the Physician's Recognition Award of the American Medical Association; approval has been requested from the American Academy of Family Physicians

MAKING SURGICAL DECISIONS

March 10-12, 1977
Medical College of Georgia, Augusta, Georgia
$100.00
Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30901; 404/828-3967
Approved for 14.75 hours credit in Category 1 of the Physician's Recognition Award of the American Medical Association

MAKING SURGICAL DECISIONS

March 10-12, 1977
Augusta, Ga.
Category 1 Credit
Contact: Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30901

DAY OF CANCER

March 14, 1977
Atlanta, Ga.
Category 1 Credit
Contact: American Cancer Society, Georgia Division, 2025 Peachtree Road NW, Atlanta, Georgia

ATLANTA GRADUATE MEDICAL ASSEMBLY

March 14-16, 1977
Atlanta, Ga.
Category 1 Credit
Contact: Winnie Hopkins, Atlanta Graduate Medical Assembly, 404-881-6128

1977 ATLANTA GRADUATE MEDICAL ASSEMBLY

March 14-16, 1977
Omni International Hotel, Atlanta
Sponsored by The Medical Association of Atlanta
Contact: Medical Assn. of Atlanta, 875 West Peachtree St., Atlanta, Ga., 30309; (404) 881-6128; 881-3862.

ENDOCRINE CAUSES OF MENSTRUAL DISORDERS

March 16-18, 1977
Hilton Inn, Memphis, Tennessee
Sponsored by The University of Tennessee Center for the Health Sciences College of Medicine
Approved for 20 elective hours by AAFP and 30 cognates by Amer. College of OB/GYN.
Contact: Div. of Continuing Education, UTCHS, 800 Madison Ave., Memphis, Tenn. 38163; (901) 528-5547.

GASTROENTEROLOGY—A CURRENT REVIEW

March 17-19
Atlanta, Ga.
Category 1 Credit
Contact: Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30901

SIXTH ANNUAL CANCER SEMINAR FOR PHYSICIANS

March 25-26, 1977
Callaway Gardens, Ga.
Category 1 Credit
Contact: American Cancer Society, Georgia Division, 2025 Peachtree Road NW, Atlanta, Georgia

PRACTICAL ASPECTS OF CORNEAL AND EXTERNAL EYE DISEASE

March 28-30, 1977
Holiday Inn of Jekyll Island, Jekyll Island, Georgia
$150.00
Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30901, 404/828-3967
Approved for Credit in Category 1 of the Physician's Recognition Award of the American Medical Association

AMERICAN COLLEGE OF SURGEON'S MEETING

March 28-31, 1977
Los Angeles, Calif.
Category 1 Credit
Contact: C. Rollins Hanlon, M.D., 55 E. Erie St., Chicago, Illinois 60611

40th ANNUAL NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

March 28-31, 1977
The Fairmont, New Orleans, La.
Registration: $125, military, $62.50, complimentary to students, residents, interns and fellows
Contact: The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Ave., New Orleans, La. 70112; (504) 525-9930.

A SYMPOSIUM ON HIRSUTISM AND VIRILISM

March 31, 1977
Executive House Augusta Convention Center, Augusta, Georgia
No registration fee
Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30901, 404/828-3967
Approval requested from the American Academy of Family Physicians

PHARMACOLOGY FOR THE ANESTHESIOLOGIST

March 31-April 2
Atlanta, Georgia
Category 1 Credit
Contact: Emory University School of Medicine, Dept. of Anesthesiology, 1365 Clifton Road NE, Atlanta, Georgia 30345

CONFERENCE ON PERINATAL MEDICINE
March 31-April 1
Callaway Gardens, Ga.
Category 1 Credit
Contact: M. L. Souma, M.D., Perinatology Dept., Medical Center, Columbus, Georgia 31901

COMPREHENSIVE STROKE CARE—A TEAM APPROACH
April 1-2
Georgia Baptist Medical Center
Contact: Mrs. Dare Domico, R.N., Stroke Unit Coordinator, 300 Boulevard, N.E., Atlanta, Ga. 30312; (404) 659-4211

HEMATOLOGY/ONCOLOGY FOR THE PEDIATRICIAN
April 4-6, 1977
Atlanta, Georgia
Category 1 Credit
Contact: Associate Dean for CME, Grady Memorial Hospital, 69 Butler St., Atlanta, Georgia 30303

AMERICAN ACADEMY OF NEUROLOGY
April 25-30, 1977
Atlanta, Ga.
Category 1 Credit
Contact: S. A. Nelson, 4015 W. 65th St., Suite 302A, Minneapolis, MN 55435

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

WEIGHT WATCHERS

2639 North Decatur Road
Decatur, Georgia 30033

For class information in the Atlanta area call: 373-5731
Outside the Atlanta area dial free: 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1976-1977

Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.

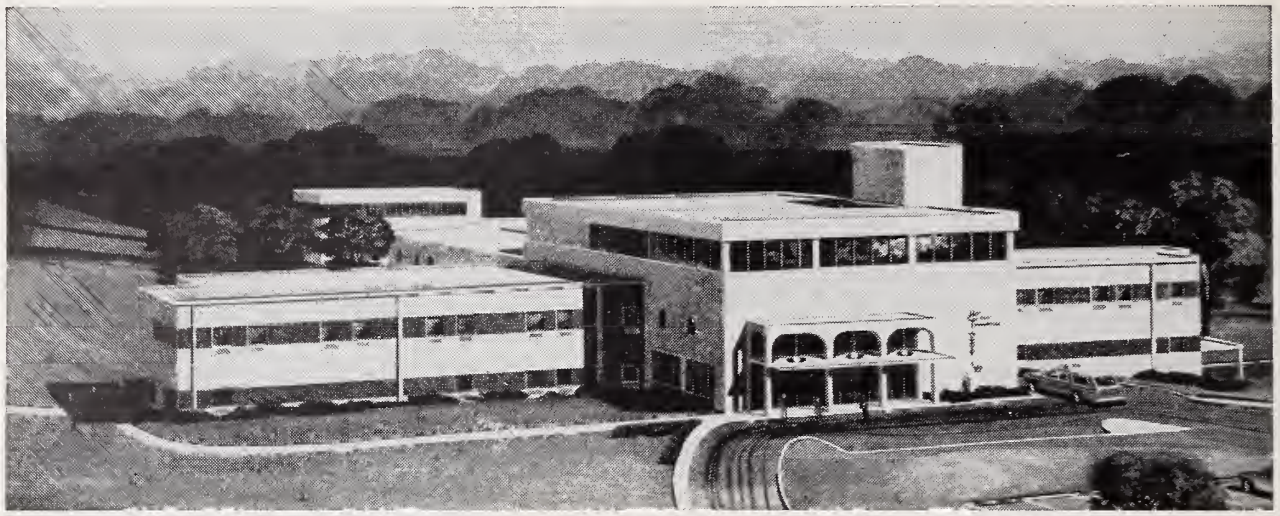
Armour Pharmaceutical Company
Greyhound Tower
111 West Clarendon Avenue
Phoenix, Arizona 85077

☐ Send latest information on Paget's Disease of Bone.
☐ Have your representative call on me.

Dr. _____

Address _____

City _____ State _____ Zip _____



HILL CREST HOSPITAL

FOR INTENSIVE TREATMENT OF PSYCHIATRIC DISORDERS

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR:
Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

20/150 H

20/100 EAR

20/70 ING IS

20/50 AS PRECIOUS

20/40 AS SIGHT HAV

20/30 YOU HAD YOUR HE

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP

250
150
90
Lidov

When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study[1] Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate[2]

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Zaroxolyn®

(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:

1. Dornfeld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* **18:** 527-533, 1975.
2. Data on file, Medical Department, Pennwalt Prescription Products.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word. For replies, your name, address and phone number should be included at the end, or an Ad number at the *Journal* may be substituted at no extra cost.

CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialities included. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

FAMILY PRACTICE: I will be moving out of state in June. I am looking for someone to buy my Family Oriented Practice of 13 years, located in the heart of DeKalb County, Georgia. If interested, contact Mel T. Moore, M.D., 3646 Market Street, Clarkston, Georgia 30021. 296-7156.

GEORGIA. Position available for General Practitioner interested in Psychiatry; also Staff Psychiatrist. This is a new 300-bed JCHA approved state psychiatric hospital. Full range of State employee benefits including retirement system and fringe benefits. Salary commensurate with training and experience. An equal opportunity employer. Georgia license or eligibility for license in Georgia required. Contact: *Dr. Henry F. Yost*, Supt., Georgia Regional Hospital at Augusta, P. O. Box 5826, Augusta, Georgia 30906.

INVESTORS NEEDED—Regional restaurant chain desires to locate in Powder Springs and Acworth on sites already selected. Investors needed to purchase sites and build for chain. Approximately $160,000.00 required. Chain will lease improvements for a 15 year period with options, and in addition to rent will pay all real estate taxes, maintenance and insurance. Investment will yield better than 12.5%. For further information call Bill Waronker, 261-4902.

INVEST IN SILVER—Rare Medallic History of the United States to celebrate the Bicentennial. 200 large, solid sterling silver medals each one with history of a different year. This complete set took over eight years to put together. Only 6,246 complete sets minted in this brilliant Proof Edition. If you are interested in this historical collection call 261-4902.

LOCATION WANTED: Family Nurse Clinician, age 31, M.S.N. Univ. of Alabama in B'ham 1973, desires joint practice with physician(s) in family practice or internal medicine, middle or north Ga. area.

NEEDED: OBSTETRICIAN-GYNECOLOGIST for private practice opportunity in small Georgia community. Privileges at our 117-bed hospital serving a population of 17,000. Guarantee of $50,000. Within one hour of metropolitan area. Contact: V. G. Davis, Director, Physician Services at (404) 255-6162 (collect) or send curriculum vitae to Charter Medical Corporation, P.O. Box 80261, Atlanta, Ga. 30366.

SEEK EMERGENCY ROOM position, full-time. 38 years old, Box No. 2-1.

8,000 SQUARE FOOT modern office building ideally located in Dalton, Georgia (due to death of Family Physician). Completely equipped. Ideal for group. Hospital nearby. Fourteen (14) examination rooms, nurses stations, four (4) private offices, lab, x-ray, surgery, and observation rooms, business offices, waiting areas, staff lounge with kitchen, doctor's lounge with shower and toilet facilities. Progressive medical community. Lease required. Call (404) 278-1050, Trust Department, First National Bank of Dalton, P.O. Box 1088, Dalton, Georgia 30720.

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

A unique hospital specializing in treatment of . . .

ALCOHOLISM
DRUG ADDICTION



In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

how do others avoid tax headaches? your CPA knows.



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

GEORGIA CPA SOCIETY

GEORGIA SOCIETY OF
CERTIFIED PUBLIC ACCOUNTANTS

4105A

Index to Advertising

Vol. 66 January 1977 No. 1

Armour Pharmaceutical Company 113

Walter Ballard Optical Company 60

Beltone Electronics Corporation 115

Brawner Hospital, Inc. 58

Burroughs Wellcome Co. 62

Classified Advertising 119

Dickey-Mangham Company 60

Eager and Simpson 108

Georgia Society of CPAs 121

Hill Crest Hospital 114

I Care, Inc. 68

Eli Lilly and Company 72

MAG Services 68

Mallinckrodt Pharmaceuticals, Inc. 123, 124

Metropolitan Psychiatric Center 66, 67

Parke, Davis and Company 57

Pennwalt Corporation 116, 117

Pharmaceutical Manufacturers Association 110, 111

Potter-Holden & Company 119

Practice Productivity, Inc. 120

A. H. Robins Company 63, 64, 65

Roche Laboratories 56, 125, 126

Roerig 70, 71, 108, 109

Smith, Kline & French 118

The Upjohn Company 69

Valley Psychiatric Hospital 60

Warner Chilcott 61

Weight Watchers of Greater Atlanta 113

Willingway Hospital 120

JOURNAL
of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.


Temporarily
STOP
Unproductive Coughs

A new product that
temporarily stops the cough

Ryna-C™
Syrup

EFFECTIVE FORMULA

- Codeine Phosphate .....10 mg
  (Warning: May be habit forming)
- Pseudoephedrine Hydrochloride .....30 mg
- Chlorpheniramine Maleate ..... 2 mg

PATIENT BENEFITS

- Provides effective cough suppression
- Provides effective decongestant action
- Alleviates nasal secretions
- Dye-free formulation
- Sugar-free formulation
- Excellent cinnamon flavor

DOSAGE

ADULT—2 tsp every 4 hours
not to exceed 6 doses in 24 hours

PEDIATRIC—2-5 years ½ tsp every 4 hours
6-12 years 1 tsp every 4 hours
not to exceed 6 doses in 24 hours

Mallinckrodt® Pharmaceuticals *Linking Chemistry to Medicine®*

Mallinckrodt, Inc.
St. Louis, MO 63147

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® IV

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFI(

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

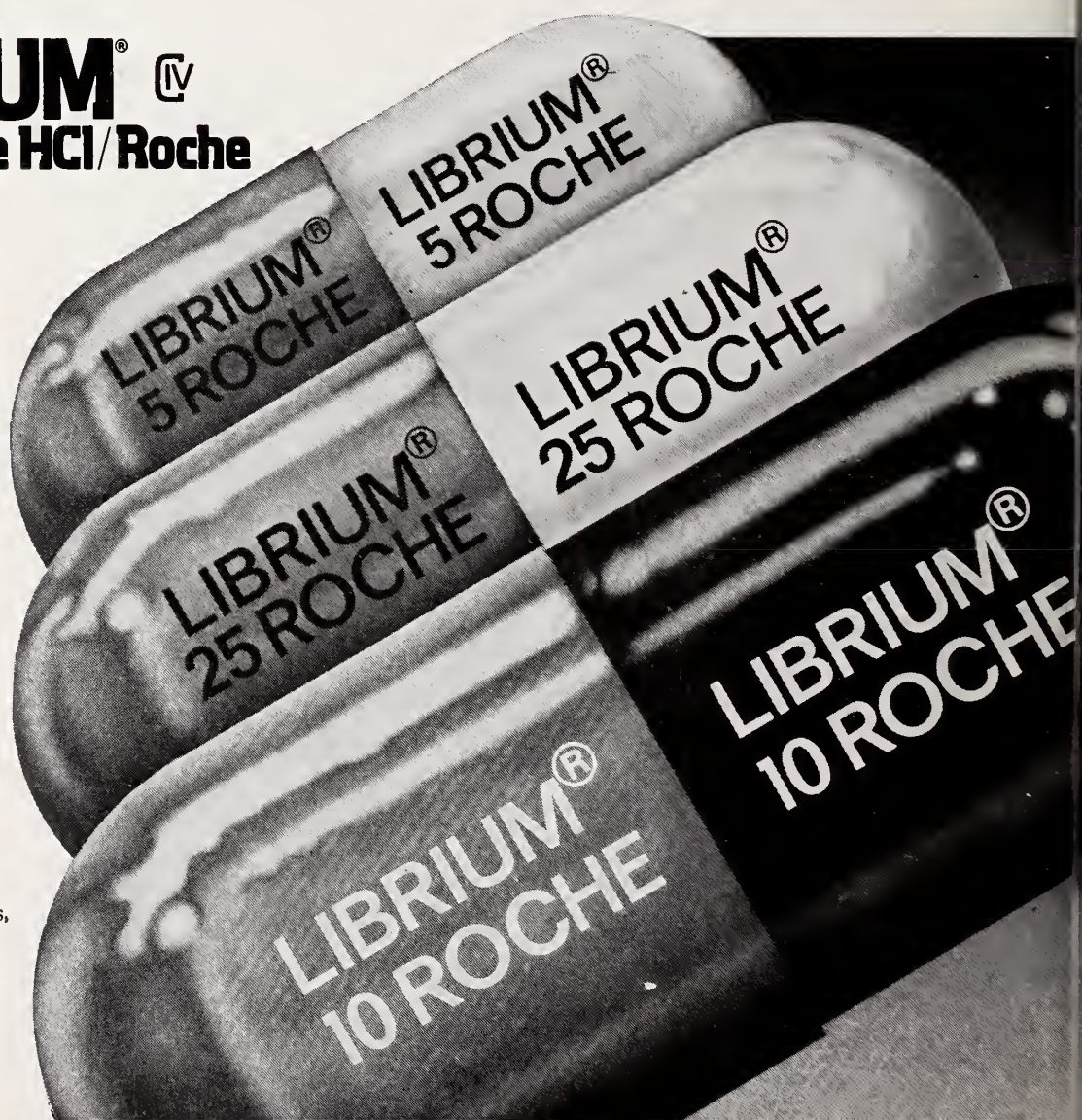
Since its discovery in the research laboratories at Roche, Lib has been the object of ongoing pharmacologic and clinical investigati

The published record on Librium is enormous. So large, in fac put it into a computer literature retrieval system to make it more acces in answering your inquiries.*

It's a record that reveals a consistent pattern of patient respor A highly favorable benefits-to-risk ratio. And minimal interference w many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ℞
chlordiazepoxide HCl/Roche

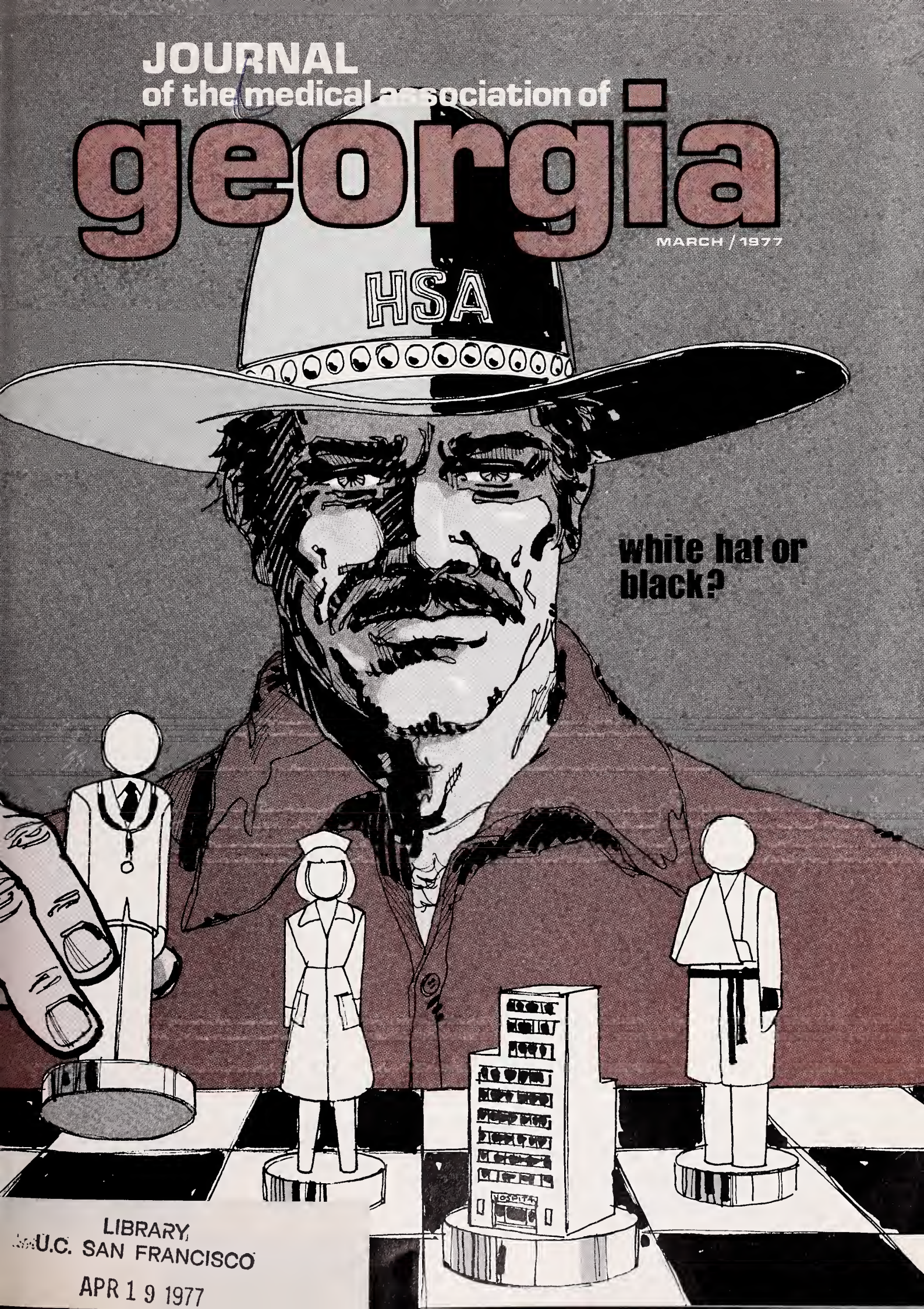


ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

JOURNAL
of the medical association of
georgia
MARCH / 1977



LIBRARY,
U.C. SAN FRANCISCO
APR 19 1977

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

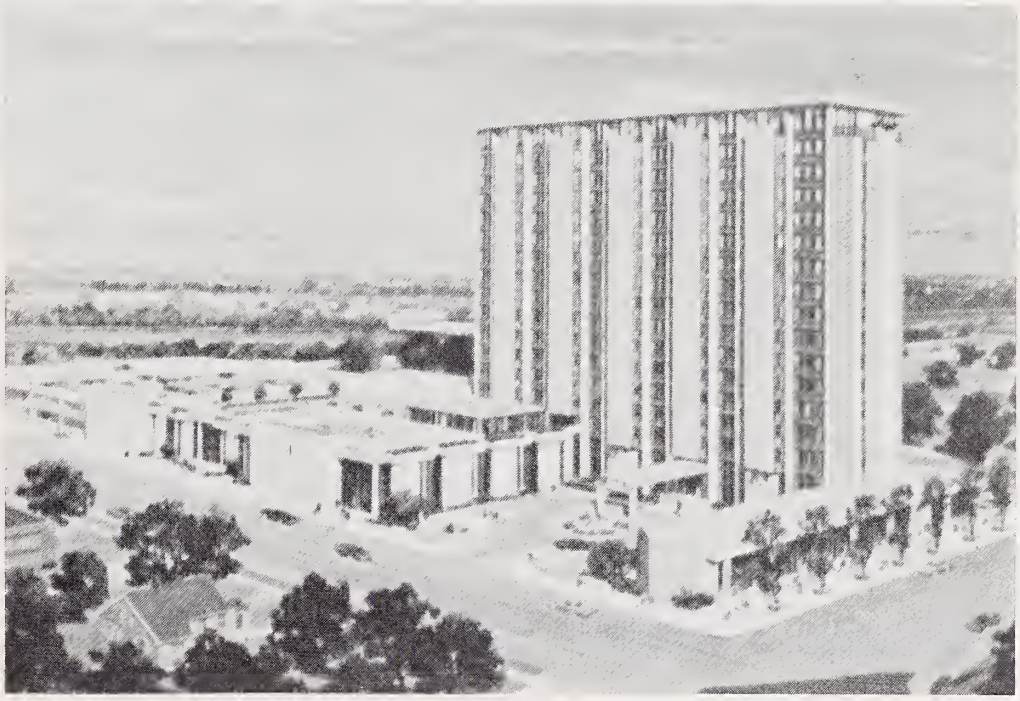
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Welcome to Macon from the Macon Hilton



First and Walnut Sts.
P. O. Box 144
Macon, GA 31202
(912) 746-1461

At The Macon Hilton you are treated in a personal, uncommercial manner. The 302 guest rooms and penthouses are large and tastefully decorated. Many overlook the Ocmulgee River. All offer direct-dial telephone, color television and room service. The Hilton caters to children; family plan available.

- Other services—including outdoor swimming—assure you of a relaxed, easy pace.
- Enjoy leisurely dining in our superb Lucian's Restaurant.
- Nightly entertainment is featured in our Silver Dollar Lounge.

"We're more than just a hotel — WE'RE THE HILTON"

BRAWNER HOSPITAL, INC.

Established 1910

3180 ATLANTA STREET, S.E.
SMYRNA, GEORGIA 30080
Telephone 404 436-0081



Located in the metropolitan Atlanta area, this psychiatric hospital is staffed by the members of the Center for Interpersonal Studies, P.A. Emphasis is placed on individual and group psychotherapy on an intensive basis. Each patient is assigned a staff psychiatrist who is responsible for the planning of an individualized treatment program, coordination of the assets of the therapeutic community and a continuing liaison with the patient's family and referring physician.

A comprehensive range of services is provided. There are facilities for evaluation and intensive treatment of patients with emotional problems which can be managed in an open psychiatric facility. An accredited high school is located on the hospital grounds and efforts are made to coordinate work with the local school system.

Member of the American Hospital Association and the National Association of Private Psychiatric Hospitals.

Accredited by the Joint Commission on Accreditation of Hospitals.

Mark A. Gould, M.D.
Medical Director

Karl S. Mihalovits, M.D.
Clinical Director

William H. Benson, M.D.
Psychosomatic Medicine

Jesse R. Peel, M.D.
Psychiatry

Ronald C. Bloodworth, M.D.
Psychiatry

Harry Porter, Jr., M.D.
Psychiatry

Herbert Gorod, M.D.
Psychiatry

Frederick W. Huff, Ph.D.
Psychology

JOURNAL
of the medical association of
georgia

contents

VOLUME 66, NUMBER 3

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF COUNCIL
Fleming L. Jolley
President
Robert E. Perry, Jr., M.D., Brunswick
President-Elect, Chairman of Council
David A. Wells, M.D., Dalton
Immediate Past President
James H. Sullivan, M.D., Columbus
First Vice President
Milton I. Johnson, M.D., Macon
Second Vice President
Earnest C. Atkins, M.D., Atlanta
Secretary
Carson B. Burgstiner, M.D., Savannah
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Ronald F. Galloway, M.D., Augusta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

147 Blood Flow Studies Following Carotid Endarterectomy, Cervical Sympathectomy and Ligation of the External Carotid Artery
Milton F. Bryant, M.D.
Don P. Giddens, Ph.D.

151 Preoperative Treatment of Ruptured Cerebral Aneurysms
Alan S. Fleischer, M.D.
George T. Tindall, M.D.

SPECIAL ARTICLES

141 Implementing P.L. 93-641: Progress of the North Central Georgia Health Systems Agency
Robert A. Youngerman

155 MAG Self-Funded Trust: Report of the Membership Insurance Committee
John T. Mauldin, M.D.

EDITORIALS

158 HSAs: Black Hats or White Hats?
Harrison L. Rogers Jr., M.D.

159 Medical Costs: Why Not a Speakers Bureau?
Edgar Woody Jr., M.D.

FEATURES

160 I've Told This Before/Navy Lieutenant on a Train
J. G. McDaniel, M.D.

162 President's Letter/Some Closing Remarks
Fleming L. Jolley, M.D.

163 Cancer Page/Testing Stool for Occult Blood to Detect Asymptomatic Large Bowel Cancer
Mario J. R. Ravry, M.D.

167 Cancer Page/Management of Congenital Ventricular Septal Defect
Willis H. Williams, M.D.

171 Legal Page/Significant Income Tax Changes in the New Tax Law
David W. Siegel
Philip J. Marzetti

173 Letter to the Editor

THE ASSOCIATION

174 New Members

174 Societies

174 Personals

175 Deaths

NEWS

150 MAG Bar-B-Q

150 Auxiliary Annual Session Social Functions

157 Harrison L. Rogers: Candidate for AMA Office

166 Vitamin C Therapy

166 Georgia Cancer Line

170 Georgia State University's Emergency Medical Technician Degree

170 AMA's Project USA

176 The Month in Washington

183 Opportunities for Continuing Medical Education

THE COVER

Health Systems Agencies have been with us for a while now. What is their role and how are they playing it? Are they good guys or bad? A detailed report starts on page 141, with an editorial on the subject on page 158. You decide. Cover art by Bob Hamill, Atlanta.

Le Bistro

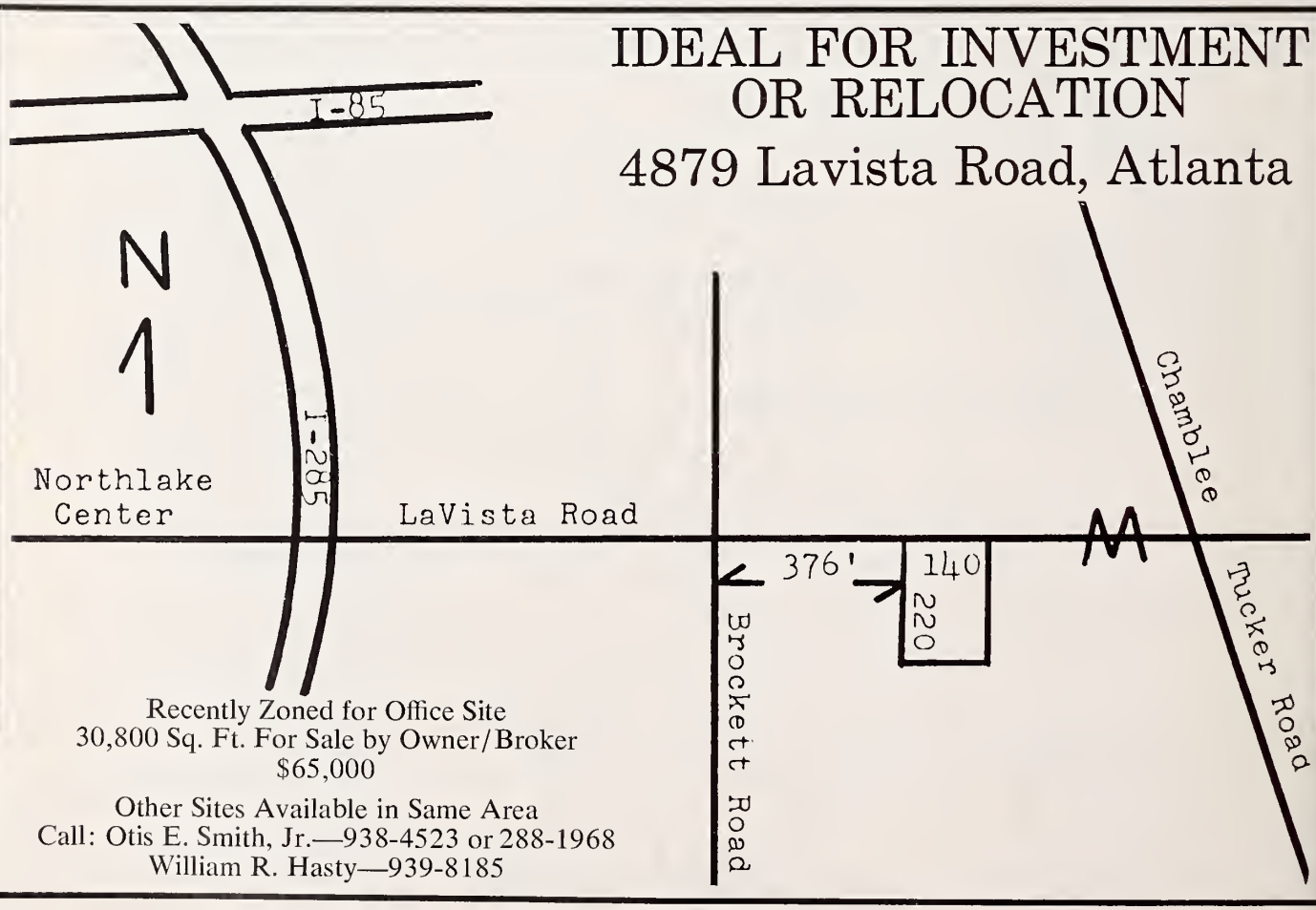
The French Restaurant in Downtown Macon



For Reservations Call 745-8624

IDEAL FOR INVESTMENT OR RELOCATION

4879 Lavista Road, Atlanta



Recently Zoned for Office Site
30,800 Sq. Ft. For Sale by Owner/Broker
$65,000

Other Sites Available in Same Area
Call: Otis E. Smith, Jr.—938-4523 or 288-1968
William R. Hasty—939-8185

how do others avoid tax headaches? your CPA knows.



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

GEORGIA CPA SOCIETY

GEORGIA SOCIETY OF
CERTIFIED PUBLIC ACCOUNTANTS

4105A

When it's pinworms, treat the family



Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD-JA-1699-2-P (8-76)

Povan® (pyrvinium pamoate)

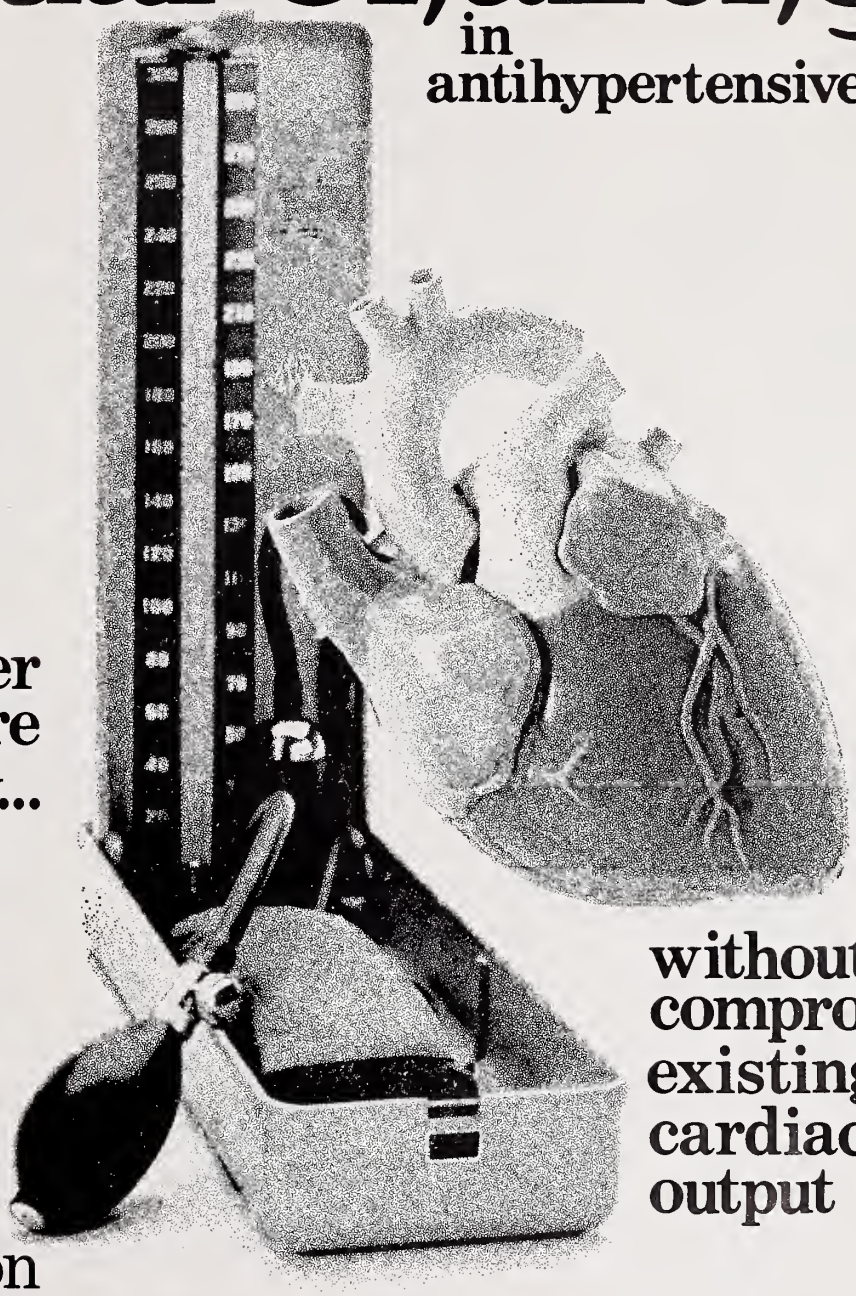
- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

Parke, Davis & Company
Detroit, Michigan 48232

A Dual Challenge in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

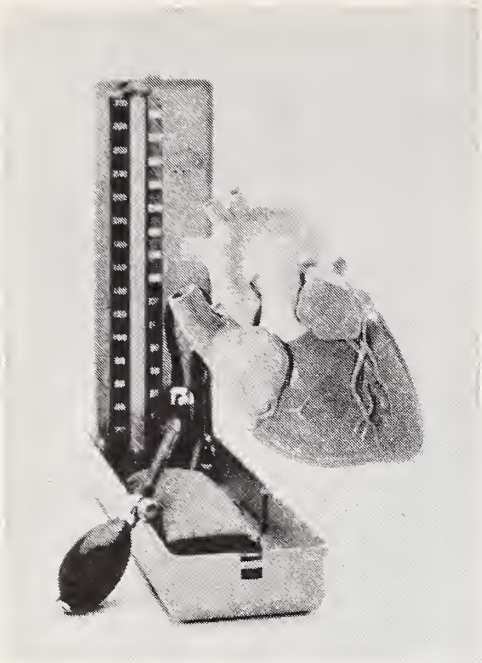
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

MSD MERCK SHARP & DOHME

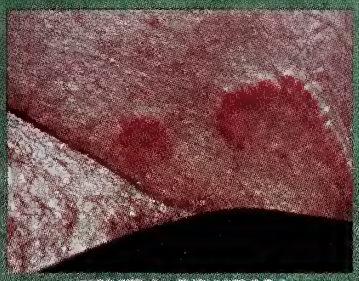
When Griseofulvin is indicated...



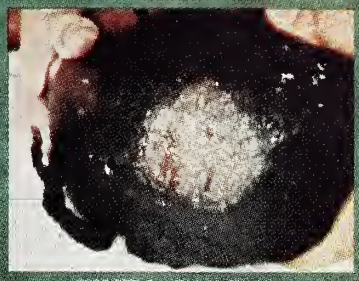
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



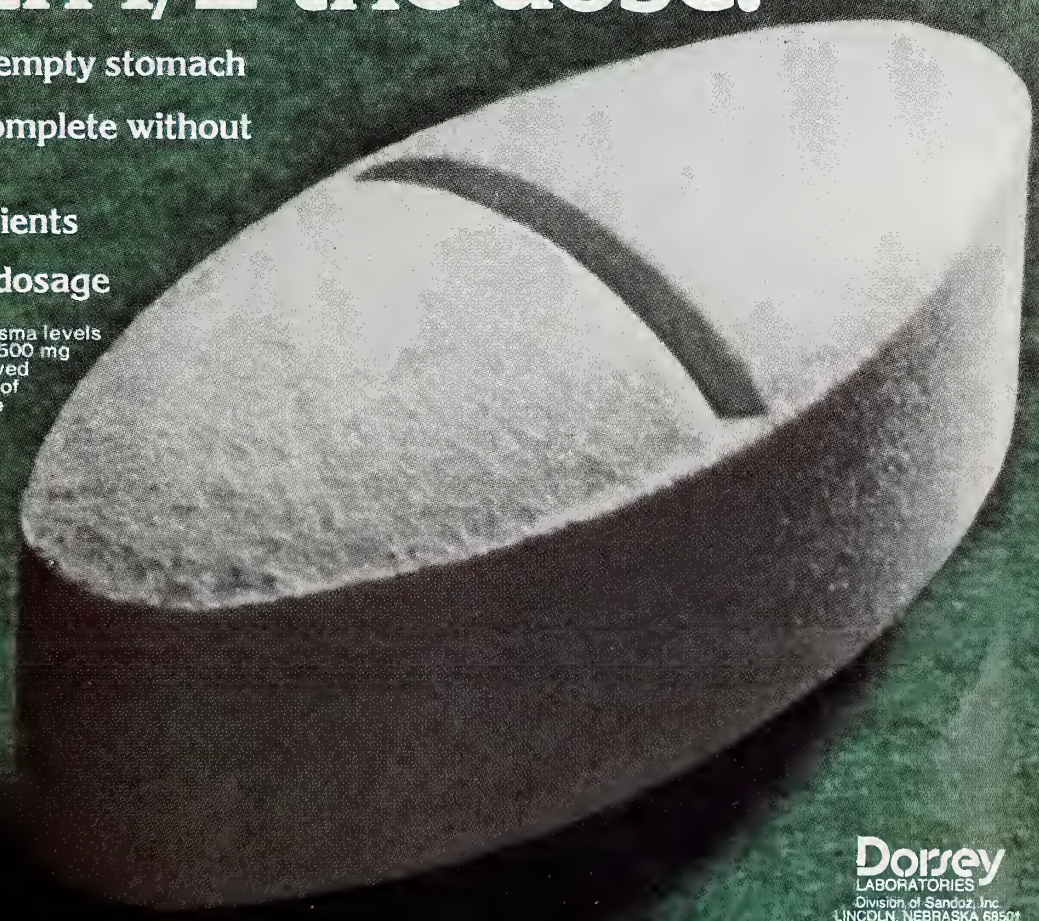
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

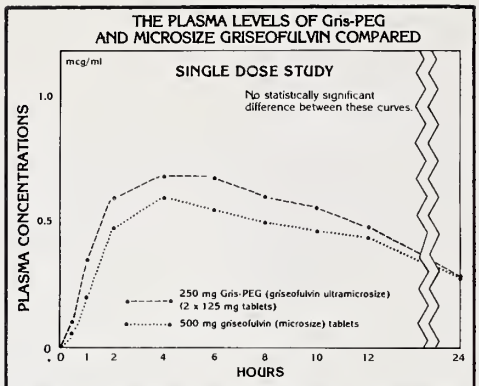
†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



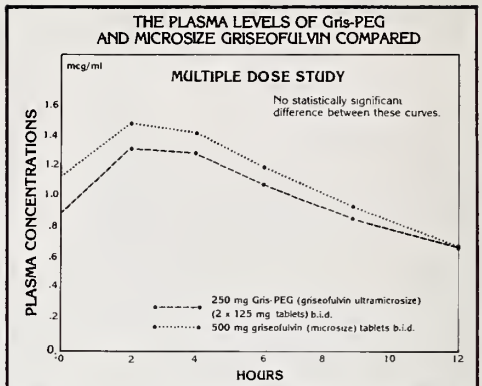
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum, Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis, tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

Dorsey LABORATORIES
Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

OY-YB

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

WEIGHT WATCHERS

2639 North Decatur Road
Decatur, Georgia 30033

For class information in the Atlanta area call: 373-5731
Outside the Atlanta area dial free: 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1976-1977

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

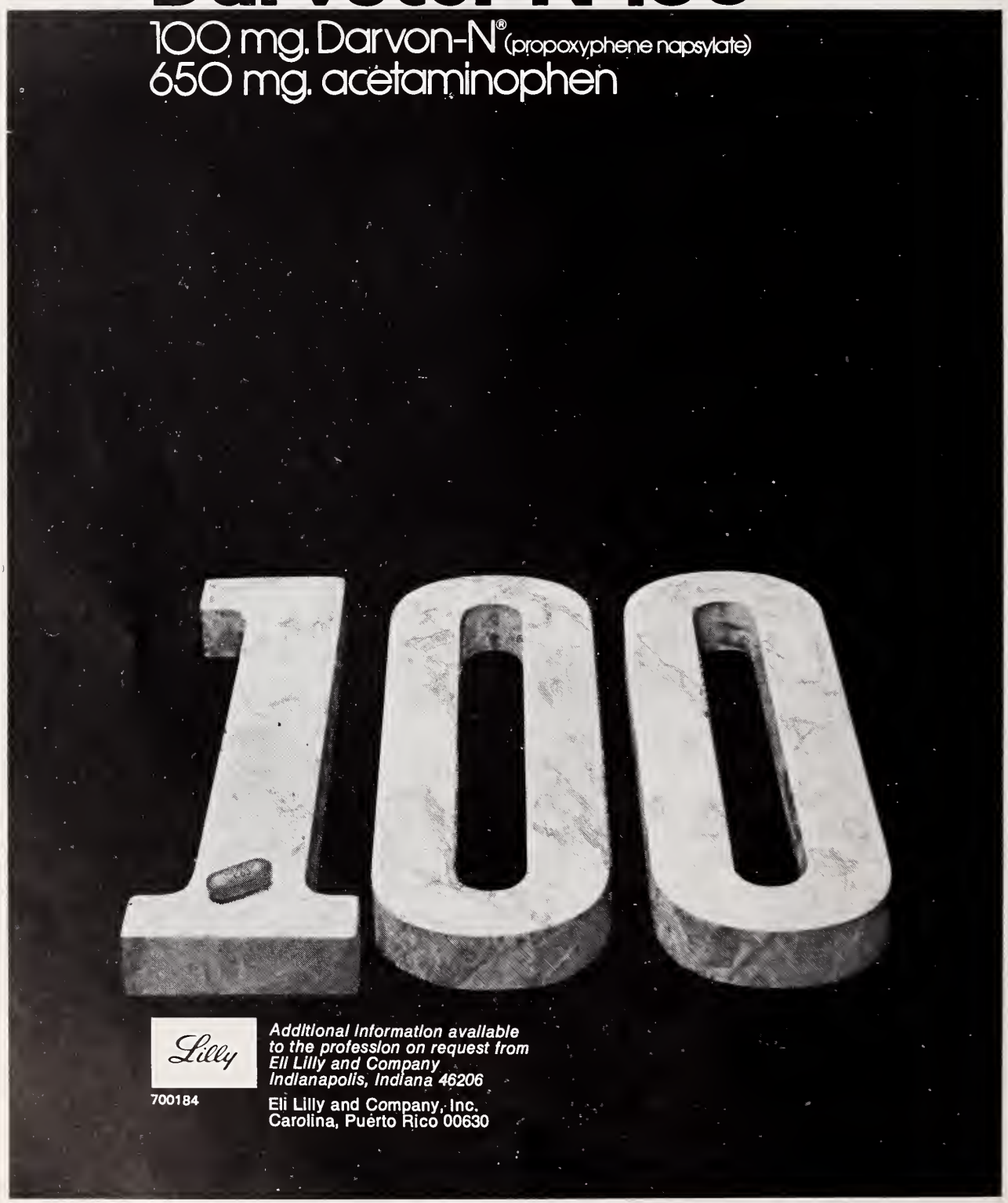
Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

contains no aspirin

tablets

Darvocet-N® 100

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

700184

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

JOURNAL
of the medical association of
georgia

Implementing P.L. 93-641

Progress of the North Central Georgia Health Systems Agency

ROBERT A. YOUNGERMAN, *Atlanta**

In the March 1975 issue of the *Journal of MAG,* J. Gordon Barrow, M.D., and I co-authored an article summarizing P.L. 93-641, the National Health Planning and Resources Development Act of 1974. Shortly after the appearance of the article, Governor George Busbee designated in May of 1975 seven health service areas in the state of Georgia. The seven areas are as follows:

Area I—Dade, Walker and Catoosa counties, with remainder of area in Tennessee surrounding Chattanooga

Area II—Appalachian Georgia—Twenty-three counties across the top of the state, including the cities of Rome, Dalton, Gainesville and Toccoa

Area III—North Central Georgia—Twenty-four counties surrounding Atlanta, including the cities of Carrollton, LaGrange, Griffin, Thomaston, Covington, Monroe and Canton

Area IV—East Central Georgia—Twenty-two Georgia counties surrounding the Augusta-Athens area, plus Aiken County, South Carolina

Area V—Central Georgia—Thirty-six Georgia counties, stretching from Columbus to Macon to the area around Dublin, plus Russell County, Alabama

Area VI—Southwest Georgia—Twenty-seven counties, including the cities of Albany, Tifton, Valdosta and Thomasville

Area VII—Southeast Georgia—Twenty-four counties including the cities of Savannah, Brunswick and Waycross

Legal Structure of HSAs

In each of the areas outlined above, a private non-profit corporation was created to apply for and receive a grant from the U.S. Department of HEW and to be designated as a Health Systems Agency (HSA) for the area it encompasses. The HSA's policies and final decisions are determined by a volunteer Board of Directors which must meet specific composition requirements contained in P.L. 93-641. The Board must have a consumer majority that is representative of the social, economic, geographic and racial interests in the area. Five categories of providers must be represented on the Board; 1) Health professionals, such as practicing physicians, dentists and nurses; 2) Institutional representatives, such as hospitals and nursing homes; 3) Health professional schools; 4) Health insurers, and 5) Allied health professionals. The providers must not be less than 40% of the Board, and *direct* providers must comprise no less than 33⅓% of the Board. *Indirect* providers are defined as anyone with a fiduciary interest in the health care field or someone in the immediate family of a direct provider, e.g. spouse of a provider, hospital authority member or member of a county board of health.

Each of the HSAs in Georgia are governed by its own bylaws which delineate the formula for membership on its Board and the process for selection to the Board. The North Central Georgia HSA has a 69-member Board of Directors and a 25-member Executive Committee. Every one of the counties in the North Central Georgia area is represented on the Board of Directors with at least one member, the larger counties having more members, according to population. The North Central Georgia HSA also has a self-imposed guideline of 20% of its Board being elected officials.

* Executive Director, North Central Georgia Health Systems Agency, Inc., Suite 700, 1447 Peachtree St., N.E., Atlanta, Ga. 30309.

A progress report on one of the seven HSAs in Georgia—what it's doing now and what its plans are for the rest of 1977.

Functions of an HSA

Under P.L. 93-641, an HSA has three primary functions: 1) To provide the health planning for its area; 2) To conduct various types of reviews of health facilities and services, and 3) To implement its plans through the development of planning projects that promote high priority items in its health plans.

Health Planning

The law states that an HSA must develop a long range health plan called a Health Systems Plan (HSP), as well as a short range plan called an Annual Implementation Plan (AIP). The way these plans differ from previous efforts at health planning is that the law requires that they describe the *present status of health* of the people in the area (prevalence and incidence of disease, mortality and morbidity figures, etc.), and what the *desired status of health* of the people ought to be. This will be accomplished by detailing goals and objectives that are based on the data available as well as the perceived needs of the people in the area. The second way an HSA's plans must differ from previous plans is that they must describe the *present system* of *delivering health care* and *what the desired system ought to be.* In other words, how can the status of health of the people and the system for delivering care be improved? At no time in the past has a health planning agency been required in such a degree of specificity to develop its plans to include these kinds of goals and objectives.

It should be mentioned at this point that every HSA in the United States must have its HSP and AIP approved by its Board of Directors—after adhering to certain federal guidelines which include, among other requirements, public hearings on the plans before they are sent to DHEW. In addition, the plans are developed during a one-to-two-year period called *conditional designation.* Once the plans are approved, the HSA may apply for *full designation.* There are certain functions under the law reserved to fully designated HSAs. Therefore, since an HSA cannot become fully designated until its HSP and AIP are approved, the primary function of an HSA during its period of conditional designation is to develop its plans. Upon full designation, the HSA must conduct additional reviews mandated by the statute, as well as being eligible to apply for development funds to assist in implementing its plans.

Reviews

During the first year of conditional designation, an HSA may, if it wishes, conduct capital expenditure reviews, under Section 1122 of the Social Security Act, for applicants who wish to receive reimbursement under Titles 18 and 19. These reviews encompass the review of capital expenditure projects in excess of $100,000, or a change in an institutional service, or a change in the number of institutional beds. After conducting the reviews, the HSA then submits its recommendations to an agency of the state government.

Once the HSA is fully designated, it must then, under the Act, review all new institutional services for need, and existing services for appropriateness (not yet defined). After completing these reviews, recommendations are made to a State Health Planning and Development Agency (SHPDA) created under another section of the Act. In addition, the HSA must review and make recommendations to the SHPDA regarding facility projects for construction, conversion, or modernization to see that such projects fit into the plans developed by the Agency. A fully designated HSA also must review and make recommendations to the SHPDA regarding projects being processed under a state certificate of need law, which under the Act, must be enacted by the state legislature within four years, or the state could be subject to a loss of federal health funds. Finally, the HSA will be reviewing for approval or disapproval other federal health funds to be expended in its area, which are authorized under the Public Health Service Act, the Community Mental Health Centers Act or the Alcohol and Drug Abuse Act. Funds subject to HSA review under these three acts must have a service component, thereby exempting most research activities.

Resource Development

The resource development function of the HSA essentially takes two forms: 1) Technical assistance to community and provider groups to develop projects and activities that promote the high priority items in its plans, and 2) To fund projects and programs that plan for the implementation of the high priority items in its plans. These funds would come from a development fund for which *fully designated* HSAs could make application.

Creation of the North Central Georgia HSA (NCG-HSA)

The North Central Georgia HSA (NCG-HSA) was incorporated under the law of the state of Georgia in November of 1975. The first meeting of the Board of Directors was on November 5, 1975. At the first meeting of the Board, Representative Michael J. Egan of Atlanta was elected temporary

chairman. Rep. Egan appointed an ad hoc Bylaws Committee and an ad hoc Nominations Committee. These committees met and prepared recommendations to the full Board on a set of Bylaws and a slate of nominees for Executive Committee membership and nominees to be officers of the corporation. Senator Virginia Shapard of Griffin was elected President of NCG-HSA at a meeting of the Board on November 22, 1975. Senator Shapard appointed a Search Committee chaired by Richard E. Hodges of Atlanta to conduct a search for an Executive Director.

In the meantime, an application for designation by DHEW to be the HSA for the area was being prepared by staff members of the Georgia Regional Medical Program (GRMP) in cooperation with staff members of the Atlanta Regional Commission (ARC). Funds from GRMP were used to support the pregrant period of NCG-HSA.

In December of 1975, the Board approved a draft application to be placed on display at a public meeting on the application which was due at DHEW in late January of 1976. At the public meeting, members of the public who were actually poor expressed concern about not having representation on the NCG-HSA Board of Directors. In approving the application for designation at a meeting in January, the Board responded to the concerns at the public meeting by recommending that the Board be expanded by seven members, four consumers, three of whom should be actually poor, and three more providers.

With the application into DHEW, the actions of the Search Committee to choose an Executive Director became the main order of business. The Search Committee met four times during December of 1975 and January of 1976. Advertisements were inserted in national and local publications, with more than seventy applications received. A code-numbered system was used to screen the candidates to five finalists. Following interviews of the five finalists by the Search Committtee and officers, the author of this article was recommended to the Board which approved the recommendation at its meeting in late February of 1976.

In April of 1976, following approval of the grant application by DHEW, the Board met to approve DHEW's designation agreement for funding. However, the Board found unacceptable certain conditions DHEW had placed on receipt of the grant and authorized the officers to negotiate with DHEW the items under dispute. The designation agreement was finally signed by the officers under protest on May 12, 1976. A notice of grant award was received in June, a staff was recruited, and an office opened at 1447 Peachtree Street, N.E. on July 1, 1976. Subsequently, the objectionable conditions on the grant award were removed by DHEW.

At the July 1976 meeting of the Board, Senator Shapard appointed members of the Board to a Planning Committee and a Review Committee. In August, September and October, the Review Committee conducted practice reviews of applications for capital expenditures under Section 1122 of the Social Security Act. In October, authority for the Review Committee to conduct Section 1122 Reviews was approved by the Board with official reviews commencing in November of 1976. In the meantime, the Planning Committee which had been appointed at the July meeting of the Board proceeded with the development of a Health Systems Plan (HSP) and Annual Implementation Plan (AIP). It formed six task forces to provide the staff and the Committee with expert advice in six identified areas which had to be addressed in the plans. These six task forces are composed primarily of non-Board members. The task forces are: 1) Prevention and Detection; 2) Primary Care; 3) Secondary/Tertiary Care; 4) Mental Health, Mental Illness, Addictive Disorders and Developmental Disabilities; 5) Environmental/Occupational Health, and 6) Data Management and Special Studies.

In order to obtain public input into a determination of perceived needs, the staff, under the auspices of the Planning Committee, held eight public meetings throughout the area during December 1976 and January 1977. More than 350 members of the public attended these public meetings and submitted numerous suggestions for incorporation into the NCG-HSA plans.

Also, during the period of July 1, 1976, when NCG-HSA became operational, to January 1, 1977, a myriad of administrative details had to be completed. These included the development and approval of personnel policies, a wage and hour salary schedule, an employee retirement plan, purchasing procedures, equipment procurement procedures, public access to information procedures, etc.

Schedule for Coming Year

At the present time, NCG-HSA has just requested from DHEW renewal of its conditional designation status. An application for renewal has just been sent to DHEW as this article goes to press. The schedule contemplates renewal on May 12, 1977. The schedule also contemplates full designation at the conclusion of NCG-HSA's 18th month, or by November 12, 1977. Since the HSP/AIP must be approved before NCG-HSA can be fully designated, the scedule calls for approval of the HSP/AIP at a special called meeting of the Board on September 7, 1977. The full schedule for HSP/AIP development and for renewal of conditional designation and for full designation can be seen on the chart which follows.

SCHEDULE

NORTH CENTRAL GEORGIA HEALTH SYSTEMS AGENCY, INC.
REVISED SCHEDULE FOR DEVELOPMENT AND COORDINATION
OF
THE HEALTH SYSTEMS PLAN (HSP), ANNUAL IMPLEMENTATION PLAN (AIP),
AND APPLICATIONS FOR RENEWAL OF
CONDITIONAL DESIGNATION AND FOR FULL DESIGNATION

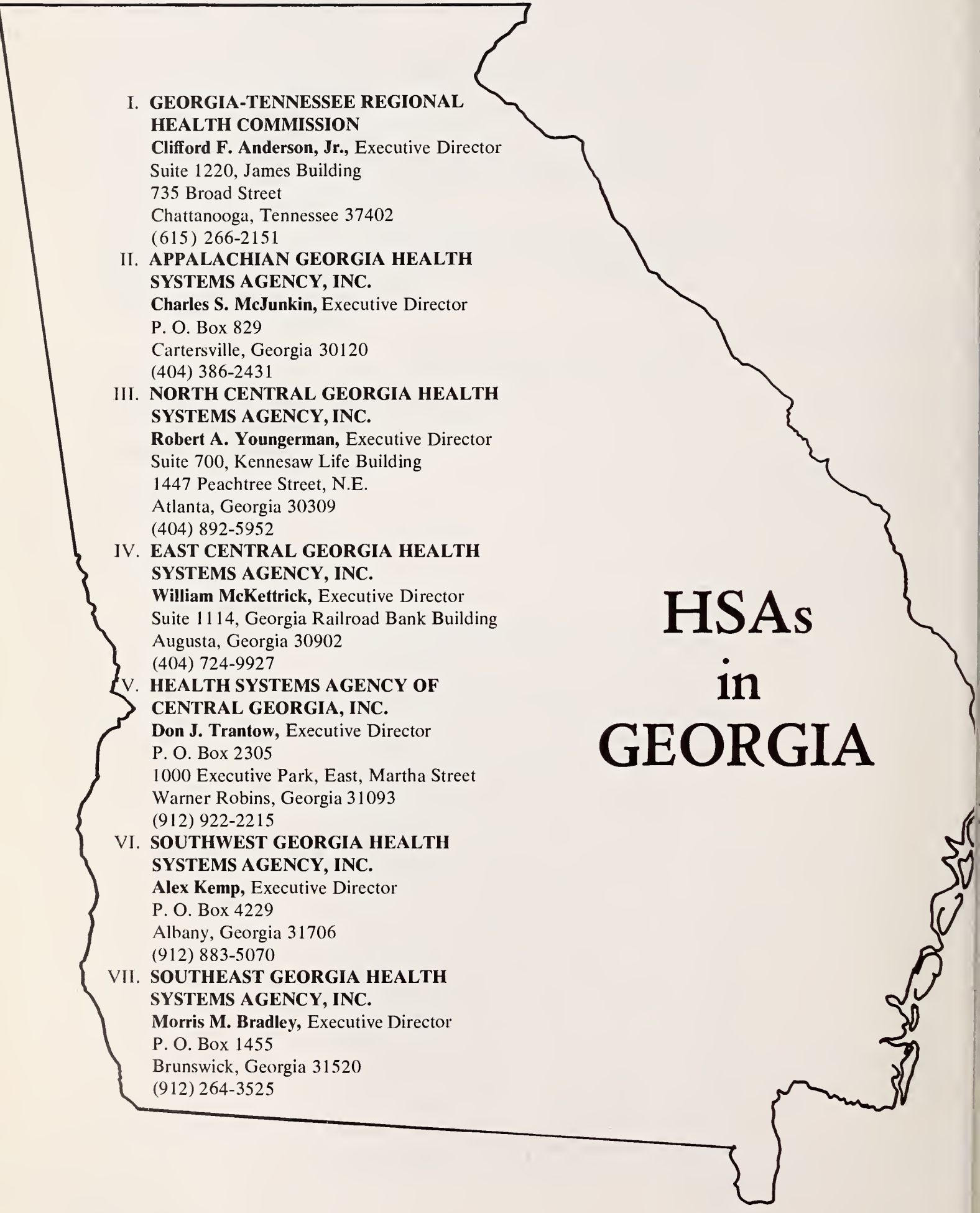
Dates	*HSP/AIP Development*	*Designation Applications*
1. December '76-January '77	Public Meetings to Determine Perceived Needs	
2. January 26, 1977	Board Meeting Review Progress of HSP/AIP Development Approve Revised HSP/AIP Development Schedule	Board Meeting Approve Work Program for Renewal Application
3. January 28, 1977		Public Notice in Newspapers of Public Meeting on Application for Renewal of Conditional Designation
4. February 1-March 31, 1977	Each Task Force Completes Analyses of Health Status and Health System, Develops Goals, Objectives and Its Portion of HSP Outline	
5. February 10, 1977		Public Meeting on Application for Renewal of Conditional Designation
6. February 15, 1977		Executive Committee Approve Application for Renewal of Conditional Designation
7. March 11, 1977		Application for Renewal of Conditional Designation to DHEW, Governor, A-95 Agencies, and Statewide Health Coordinating Council
8. April 1-15, 1977	Each Task Force Obtains Public Input and Sets Its Priorities	
9. April 13, 1977	Mailout of Task Force Goals, and Objectives and Detailed Outline of HSP to Board of Directors	
10. April 15-May 15, 1977	Planning Committee Completes HSP Goals, Objectives and Priorities	
11. April 27, 1977	Board Meeting Review Initial Draft of HSP Goals, Objectives Review Initial Draft of HSP/AIP Outline	
12. April 15-June 30, 1977	Staff Completes Draft of Narrative of HSP/AIP	Staff Prepare Full Designation Application
13. May 12, 1977		Begin Second Year of Conditional Designation
14. July 1, 1977	Mail Initial Draft of HSP/AIP to Planning Committee	
15. July 11, 1977	Planning Committee Approves Initial Draft of HSP/AIP	
16. July 12, 1977	Public Notice in Newspapers of Public Hearings on HSP	Public Notice in Newspapers on Application for Full Designation
17. July 15, 1977	Mail Initial Draft of HSP/AIP to Board	Mail Draft Application for Full Designation to Board
18. July 27, 1977	Board Meeting Approve Initial Draft of HSP/AIP for Presentation at Public Hearings	Board Meeting Approve Draft Application for Full Designation for Presentation at Public Hearings

Dates	*HSP/AIP Development*	*Designation Applications*
19. August 12, 1977	Public Hearings on HSP	Public Hearings on Application for Full Designation
20. August 1-24, 1977	Staff Integrates Board and Public Comments into Final HSP/AIP Draft	Staff Integrates Board and Public Comments into Application for Full Designation
21. August 24, 1977	Mailout to Board of Final Draft of HSP/AIP	Mailout to Board of Application for Full Designation
22. September 7, 1977	Special Called Meeting of the Board of Directors. Final Approval of HSP/AIP	Special Called Meeting of the Board of Directors Final Approval of Application for Full Designation
23. September 12, 1977	Transmittal of HSP/AIP to DHEW and Other Agencies with Application for Full Designation	Transmittal to DHEW and Georgia State Health Planning and Development Agency (SHPDA) of Application for Full Designation (Includes HSP/AIP)
24. September 13-16, 1977	HSP to Libraries and Notice in Newspapers That It Is Available for Inspection	
25. November 11, 1977		End of Period of Conditional Designation (18 MONTHS)
26. November 12, 1977		BEGIN PERIOD OF FULL DESIGNATION

Summary

P.L. 93-641 is an extremely complex piece of legislation. Its goals of improving accessibility to care and availability of care at a reasonable cost are not subject to great dispute. What often is not fully understood by many is that NCG-HSA, in attempting to fulfill the requirements of the law, serves as the only link between the federal government and the private sector in the health field. It is a private, non-profit corporation and its decision-making authority is in the hands of a coalition of all types of consumers, providers and elected officials, whose intent is to hear all points of view so that difficult decisions can be made in a reasonable and responsible manner.

The effect of NCG-HSA's planning and development activities will not be felt until much later. Planting the seed of how to avoid wasteful and expensive duplication of facilities and services through good health planning does not have a short-range payoff. However, if the approach by NCG-HSA can be maintained—namely to serve as a community advocate for improved health care while working in a cooperative manner with the health professionals, whose goals really are no different from those of consumers or non-professionals—there is a reasonable opportunity for NCG-HSA to make a positive contribution towards a more responsive health care system.



I. **GEORGIA-TENNESSEE REGIONAL HEALTH COMMISSION**
Clifford F. Anderson, Jr., Executive Director
Suite 1220, James Building
735 Broad Street
Chattanooga, Tennessee 37402
(615) 266-2151

II. **APPALACHIAN GEORGIA HEALTH SYSTEMS AGENCY, INC.**
Charles S. McJunkin, Executive Director
P. O. Box 829
Cartersville, Georgia 30120
(404) 386-2431

III. **NORTH CENTRAL GEORGIA HEALTH SYSTEMS AGENCY, INC.**
Robert A. Youngerman, Executive Director
Suite 700, Kennesaw Life Building
1447 Peachtree Street, N.E.
Atlanta, Georgia 30309
(404) 892-5952

IV. **EAST CENTRAL GEORGIA HEALTH SYSTEMS AGENCY, INC.**
William McKettrick, Executive Director
Suite 1114, Georgia Railroad Bank Building
Augusta, Georgia 30902
(404) 724-9927

V. **HEALTH SYSTEMS AGENCY OF CENTRAL GEORGIA, INC.**
Don J. Trantow, Executive Director
P. O. Box 2305
1000 Executive Park, East, Martha Street
Warner Robins, Georgia 31093
(912) 922-2215

VI. **SOUTHWEST GEORGIA HEALTH SYSTEMS AGENCY, INC.**
Alex Kemp, Executive Director
P. O. Box 4229
Albany, Georgia 31706
(912) 883-5070

VII. **SOUTHEAST GEORGIA HEALTH SYSTEMS AGENCY, INC.**
Morris M. Bradley, Executive Director
P. O. Box 1455
Brunswick, Georgia 31520
(912) 264-3525

HSAs in GEORGIA

Interesting clinical implications of intraoperative blood flow studies in five selected patients are discussed.

Blood Flow Studies Following Carotid Endarterectomy, Cervical Sympathectomy and Ligation of the External Carotid Artery

MILTON F. BRYANT, M.D. *and* DON P. GIDDENS, Ph.D., *Atlanta**

In 1938, Mann and his associates[1] evaluated the effect on the blood flow of decreasing the lumen of a blood vessel. It has been shown by many investigators that little change in flow occurs until a marked and critical degree of stenosis is reached. Numerous studies have confirmed the fact that a 65-75 percent reduction in the cross-sectional area is necessary to significantly interfere with blood flow. Youmans and Kindt[2] have stressed the observation that the length of the stenosed segment influences the point of critical stenosis. In 1964, Roberts and associates[3] reported their classic studies on extracranial cerebral blood flow.

The development of arteriography provided the necessary information for the development of vascular procedures to correct stenotic and occlusive lesions in the extracranial arterial system. New microsurgical techniques[4] now allow corrective surgery to be performed upon the intracranial arteries, and successful reports are occurring with increasing frequency. Innumerable reports have been published indicating the value of carotid endarterectomy in preventing cerebral infarction.[5-8] Various techniques and adjunctive procedures have been used in performing corrective carotid artery surgery. The purpose of this study is to report the blood flow changes following carotid endarterectomy with and without sacrifice of the external carotid artery. In addition, an attempt has been made to evaluate the effect of cervical sympathectomy upon the flow in the post-endarterectomized internal carotid artery.

Method

Blood flow studies have been performed intraoperatively upon five selected patients who were undergoing carotid endarterectomy for transient cerebral ischemic attacks. Their ages ranged between 68 and 75 years. Three patients were female and two were male. Complete medical evaluation revealed all patients to be in excellent physical condition with normal blood pressure and normal cardiopulmonary states. These patients expressed no complaints other than transient focal neurological deficits. Electrocardiographic studies, chest X rays and routine laboratory studies were all within normal limits. Technetium brain scans were normal in all patients. Oculoplethysmographic and carotid phonoangiographic studies were positive for marked unilateral obstructive disease in each patient. Arteriographic studies revealed tight segmental stenoses (at least

* Suite 225, Piedmont Professional Building, 35 Collier Rd., N.W., Atlanta, Ga. 30309. Dr. Bryant is a clinical associate professor of surgery at Emory University and an attending surgeon at Piedmont Hospital. Dr. Giddens is an associate professor of Aerospace Engineering, Georgia Institute of Technology.

80 percent reduction in diameter) involving the proximal portion of the right or left internal carotid artery. The opposite internal carotid arteries were angiographically normal, as were the vertebral arteries.

Corrective surgery was performed with the patient under light halothane anesthesia. Since the surgical trauma associated with carotid endarterectomy is rather minimal, no problems were encountered in keeping the blood pressure and pulse rates stable and the PO_2 and PCO_2 within normal ranges. The carotid sinus nerve was not blocked with Procaine, and every effort was made to protect the nerve fibers supplying the carotid sinus and the carotid body. The arteriotomy incision was closed with #6-0 braided dacron sutures inserted in a continuous fashion. The Doppler probe and the electromagnetic flowmeter were used to check the flow prior to and following surgery upon the carotid artery. Data was obtained, recorded and interpreted using equipment from the Department of Aerospace Engineering at the Georgia Institute of Technology. All patients were operated upon uneventfully and have recovered fully. To date, no patient has had further transient cerebral ischemic attacks; although the longest followup has been only 14 months.

Instrumentation

After exposure of the carotid arteries, these vessels were handled using the "minimal touch" technique in order to prevent embolism and not influence the baroreceptor reflex.[9] Blood flow studies were recorded using three Carolina electromagnetic probes —one probe about the common carotid artery proximal to the plaque, another probe about the internal carotid artery distal to the plaque, and the third probe placed about the external carotid artery. Four thousand units of heparin were given so that flow measurements prior to endarterectomy and post-endarterectomy were made with heparin on board. In all instances, flow studies were performed in duplicate and, at times, in triplicate.

The instantaneous volume flow rates were measured with a Carolina Medical Electronic Square Wave electromagnetic flowmeter, Model 501. Cuff-type probes were employed and were placed with a snug, but not constrictive, fit about the vessel being studied. Probe factors were adjusted for the hematocrit of the patient. The instantaneous flow rate output was recorded on a strip chart recorder (Hewlett-Packard, Model 7702B). This signal was also input to an integrating voltmeter (Hewlett-Packard, Model 2401C) for the determination of mean flow rates. The instantaneous flow rate, as determined by the electromagnetic flowmeter, was integrated for 30 seconds to obtain mean flow rate values. This could then be divided by the number of heartbeats during the time to obtain a mean flow rate per beat. Results:

Pre-Carotid Endarterectomy Flow Studies

As one would expect, the minute flow rate in the common carotid artery was equal to the combined flow rates in the internal and external carotid arteries. The average minute flow rate in the internal carotid artery distal to the obstruction, prior to surgery, was 69 ml/min. The average flow rate in the external carotid artery was 122 ml/min. Flow in the common carotid artery prior to surgery was 191 ml/min.

Post-Carotid Endarterectomy Flow Studies

Following relief of the stenosis in the internal carotid artery, the minute flow in the internal carotid artery doubled, tripled or quadrupled. In one patient, the flow increased to 273 ml/min., which is approximately the minute flow rate one would expect the normal internal carotid artery to have; i.e., 335 ml/min.

External Carotid Artery Clamped Post-Carotid Endarterectomy

Our data shows that clamping of the external carotid artery following carotid endarterectomy causes an immediate further 10-12 percent increase in total minute flow in the internal carotid artery. This finding was constant and could be duplicated by unclamping and repeating the flow measurements. The increase in flow continued for at least 15 minutes, at which time the procedure was terminated.

Cervical Sympathectomy Following Carotid Endarterectomy

A cervical sympathectomy was performed in all patients, removing the superior cervical sympathetic ganglia. Blood flow studies did not reveal an immediate increase or decrease in flow through the endarterectomized internal carotid artery.

Discussion

It has been determined by a number of investigators that approximately 15 percent of the cardiac output supplies the brain, even though the brain constitutes only about two percent of the body weight. Approximately 335 ml/min. of flow occurs in each normal carotid artery and approximately 40 ml/min. in each normal vertebral artery. This gives a total of 750 ml/min. total cerebral blood flow. In general, the above values do not vary with age, as long as no disease process is present. Poiseulle's Law correlates the factors which determine the flow of fluids through a tube. This formula relates to rigid tubes with streamlined flow and may not always be applied to the human arterial system with its many

variables. Loss of forward pressure may occur as the result of turbulent flow. Hot film probe anemometer studies by Giddens and associates[10] have shown turbulence caused by lesions producing no more than 20 percent stenosis, with marked increase in turbulence as the stenosis increases.

These studies confirm the reports of others that there is a marked decrease in flow through an artery when the degree of stenosis involves 65-75 percent or more of the normal cross-sectional area. In one of our patients, the flow distal to a 98 percent stenotic lesion was recorded as zero blood flow. Following correction of the stenosis, blood flow was measured at 200 ml/min. Our findings are not unusual and correlate with the reports of many other investigators.

It was postulated that by ligating the external carotid artery, a portion of the volume of flow in the external carotid artery might be diverted to the internal carotid artery and, thereby, increase the total cerebral flow in these patients. Our studies confirmed this postulate as a 10 percent increase in flow in the endarterectomized internal carotid artery occurred following ligation of the external carotid artery. This finding has led us to sacrifice the carotid bulb region, ligate the external carotid artery, perform an eversion endarterectomy and restore arterial continuity, by performing an end-to-end anastomosis between the common and internal carotid arteries with #6-0 dacron sutures in our patients with unilateral, segmental, extracranial, internal carotid artery stenosis. Common carotid compression for two minutes preoperatively is performed routinely to determine if a shunt is needed.[11, 12] To date, we have operated on 100 patients using this technique and have been pleased with the results. In our opinion, eversion endarterectomy is easy to perform and we have noted no difficulty with unilateral loss of the carotid body and the carotid sinus. Three patients have developed temporary, intermittent claudication of the ipsilateral muscles of mastication. This problem has cleared spontaneously within a period of two to four months.

We do not advocate using this technique bilaterally. Loss of the baroreceptor reflexes from both carotid sinuses may lead to hypertension which is difficult to control and this is especially true if hypertension is present preoperatively. Black-out spells may occur occasionally when the patient suddenly assumes the upright position following sacrifice of both carotid sinuses.

Respiratory problems in critically ill patients have recently been reported from the Peter Bent Brigham Hospital in patients who have had both carotid bodies removed.[13] We do not advocate removal of both carotid bodies.[14]

Under normal conditions, the resistance of the cerebral vessels is varied so as to maintain a constant blood flow despite changes in the perfusion pressure. This tendency to maintain constant flow is known as the autoregulation phenomenon. Several theories have been advanced to explain this phenomenon; however, all of them are still under dispute. The myogenic theory, tissue pressure theory, neurogenic theory and the metabolic theory all may, at times, work in harmony to maintain a constant cerebral blood flow.

By removing the first cervical sympathetic ganglia, we had hoped to decrease the peripheral resistance and increase the total minute blood flow through the endarterectomized internal carotid artery. In two of our patients, no change in flow occurred and in three patients the increase was so small as to be insignificant. It can be stated without question that cervical sympathectomy does not immediately decrease flow in the internal carotid artery. One can only speculate what the long term results may be. All five patients developed the typical Horner's syndrome which caused insignificant and temporary symptoms. Most of the features of the Horner's syndrome were not noticed by these elderly patients, and in three to four months the lid lag was barely detectable. Further studies should be carried out; however, at the present time cervical sympathectomy may be considered when the obstruction in the internal carotid artery cannot be relieved and nothing else can be done to improve cerebral blood flow. One may also consider cervical sympathectomy when multiple intracranial stenoses are present and one is performing corrective surgery upon an area of severe stenosis in the extracranial internal carotid artery. This suggestion is based on the clinical improvement we have seen in patients subjected to cervical sympathectomy. As stated above, we have no blood flow data to support this clinical impression.

Summary

1. Stenotic lesions in the internal carotid artery produce marked decrease in minute blood flow when the degree of stenosis involves more than 65-75 percent of the normal cross-sectional area.

2. These flow studies suggest that sacrificing the external carotid artery following carotid endarterectomy will produce a further immediate 10 percent increase in minute blood flow in the internal carotid artery.

3. We could not detect any immediate increase in blood flow in the internal carotid artery following cervical sympathectomy. Cervical sympathectomy may be considered when corrective arterial surgery cannot be accomplished or when multiple intracranial lesions are present and one is correcting an area of severe stenosis in the extracranial internal carotid artery. This suggestion is based on subjective

clinical impressions and not on objective flow data. Final evaluation must await further studies.

REFERENCES

1. Mann, F. C., Herrick, J. F., Essex, H. E. and Baldes, E. J.: "The effect on the blood flow of decreasing the lumen of a blood vessel." *Surg.* 4:249-252, 1938.
2. Kindt, G. W. and Youmans, J. R.: "The effect of stricture length on critical arterial stenosis." *Surg. Gynec. Obstet.* 128:729-734, 1969.
3. Roberts, B., Hardesty, H. W., Holling, H. E., Reivich, M. and Toole, J. F.: "Studies on extracranial cerebral blood flow." *Surg.* 56:826-833, 1964.
4. Donaghy, R. M. P. and Yasargil, G.: *Microvascular Surgery,* St. Louis, C. V. Mosby Co., 1967.
5. Rob, C.: "Surgical treatment of stenosis and thrombosis of the internal carotid, vertebral and common carotid arteries." *Proc. Roy. Soc. Med.* 52:549-552, 1959.
6. Thompson, J. E., Austin, D. J. and Patman, R. D.: "Endarterectomy of the totally occluded carotid artery for stroke." *Arch. Surg.* 95:791-801, 1967.
7. Bryant, Milton F.: "Surgical treatment of cerebral vascular insufficiency." *Ann. Surg.* 154:182-186, December, 1961.
8. Bryant, Milton F.: "Surgical treatment of carotid artery obstructions." *J.M.A.G.* 60:366-369, November, 1971.
9. Singhabhandhu, Bhongtep, Gray, Stephen W., Bryant, Milton F. and Skandalakis, John E.: "Carotid body tumors." *Am. Surgeon* 39:501-508, September, 1973.
10. Giddens, Don P., Mabon, Robert and Cassonova, Robert A.: "Measurements of disordered flows distal to subtotal vascular stenoses in the thoracic aortas of dogs." *Circul. Res.* 39:112-119, July, 1967.
11. Bryant, Milton F.: "Anatomical considerations in carotid endarterectomy." *Surg. Clin. N. Am.,* December, 1974.
12. Bryant, Milton F.: "Complications associated with carotid endarterectomy." *Am. Surgeon* 42:665, 1976.
13. Ingram, Roland, M.D.: Personal communication.
14. Davidson, Joseph T., Whipp, Brian J., Wasserman, Karlman, Koyal, Sandar, N. and Lugliani, Robert: "Role of the carotid bodies in breath-holding." *N. Eng. J. Med.* 290:819-822, January-June, 1974.

MAG ANNUAL SESSION
BAR-B-Q

for

Delegates, Alternates, Members,
Auxiliary and Families

$7.50 per Adult • $5.00 per Child Under 12
(Price is All-Inclusive)
Transportation Provided from Hilton Hotel

For Tickets, send request and check to:
Sherwood Williams
MAG Headquarters
938 Peachtree St., Atlanta 30309

FRIDAY, APRIL 22, 1977
6:30-9:30 PM
FICKLING FARMS

Good Food—Drink—Plus Live Music

AUXILIARY SOCIAL FUNCTIONS
ANNUAL SESSION—MACON

April 21-24, 1977

Thursday, April 21

Reception Honoring 1976-77 Executive Board
6:30-7:30 pm

Friday, April 22

Luncheon—Idle Hour Country Club
Hospitality: 12:30-1 pm
Lunch: 1-2:25 pm
Special Tour of Decorators' Showcase Home
Board Buses: 2:30 pm

Saturday, April 23

Tour of Historic Macon Homes
1-3 pm
(Coffee will be served in one of the homes)

Sunday, April 24

Coffee in the Elm Room
10 am-12 noon

Preoperative Treatment of Ruptured Cerebral Aneurysms

ALAN S. FLEISCHER, M.D. *and* GEORGE T. TINDALL, M.D., *Atlanta**

THERE HAVE BEEN MANY important recent developments and refinements in the diagnosis and pre-operative management of the patient with a ruptured intracranial aneurysm. As a result of these important contributions, there has been a gratifying decrease in operative morbidity and mortality. The purpose of this article is to discuss the innovations that have resulted in the improved management of these lesions.

Rupture of a congenital intracranial aneurysm is the most common cause of spontaneous subarachnoid hemorrhage (SAH) in the adult. These lesions were rarely diagnosed and treated until the development of cerebral angiography by Egas Moniz in 1927.[17] In 1933, Norman Dott became the first person to operate on a cerebral aneurysm previously demonstrated by carotid angiography.[4] Many of the modern intracranial procedures for the correction of aneurysms were developed during the following five years, and it was Walter Dandy in 1938 who first directly occluded the neck of a saccular aneurysm with a silver clip.[3]

There followed a period of aggressive early surgery for those patients who survived the initial hemorrhage from a ruptured aneurysm. However, results generally were poor and an increasing disenchantment with direct surgical therapy for intracranial aneurysms developed, an attitude that prevailed until the mid-1960's. Three factors were primarily responsible for these early poor results. First, the overall management including the surgery was unsophisticated compared to present day techniques which include improved illumination and magnification with the operating microscope, hypotensive anesthesia, corticosteroids and osmotic diuretics, all of which facilitate the operative procedure. These new innovations have significantly reduced operative morbidity and mortality rates and have made intracranial aneurysm obliteration the treatment of choice in most instances.

Recent innovations have resulted in improved management of these lesions.

Second, surgery was often performed without due consideration of the patient's neurological status following aneurysm rupture, or complicating factors such as advanced age and coexistent medical or surgical illnesses. The influence of these factors on the morbidity and mortality of aneurysm surgery eventually led to the development of a grading system which quantitated the severity of the hemorrhage and provided a rational approach to the management of patients within each classification. Many grading systems have been described, but the most widely used is that of Botterell.[2] Most neurosurgeons now agree that patients categorized as grade 4 or 5 (comatose) should not be subjected to elective aneurysm surgery, and should only be operated upon for evacuation of an intracerebral hematoma or hydrocephalus since recovery is unlikely because of the effect of the initial hemorrhage on the brain; patients in either grade 1 or 2 should be considered surgical candidates and managed preoperatively according to the outline presented below, while grade 3 patients are in a grey-zone, and their ultimate management depends on the judgment and experience of the neurosurgeon.

A third reason for early poor results was that most of the operative procedures in the early phases

* Division of Neurosurgery, Emory University School of Medicine, Grady Memorial Hospital, 80 Butler St., S.E., Atlanta, Ga. 30303.

of aneurysm surgery were performed immediately following the aneurysm rupture in fear of the prospect of rebleeding. This was usually the time of maximal brain swelling and the effect of surgery on the brain was deleterious. Also, several years passed before cerebral vasospasm was appreciated as a major problem following early surgery. Ecker and Riemenschneider first documented vasospasm angiographically in their patients who were recovering from aneurysm rupture in 1950.[6] Subsequent contributions by Norlen and Olivecrona,[20] by Logue,[14] and by Pool[23] established cerebral vasospasm as an important clinical entity and suggested the incidence may be increased by early surgery following aneurysm rupture. Early surgery clearly was technically more difficult and caused further brain swelling as well as increased the risk of vasospasm. However, the incidence of rebleeding from a ruptured intracerebral aneurysm increases by the second postbleed day and is maximal by day seven; by the end of the second week, up to 22 percent of patients with a ruptured aneurysm will experience a rebleed, and many of these will be fatal.[13] Drake has stated: "It is probably true that if we could learn how to keep a patient safe from rebleeding for a week or longer, especially in obtunded patients with cerebral symptoms, the problems of surgery of ruptured intracranial aneurysms would nearly be solved."[5]

Intentional delays in operative intervention necessitated the development of techniques for managing the problems that may follow aneurysm rupture which include:

- Intracerebral hematomas
- Increased intracranial pressure
- Hydrocephalus
- Rebleeding
- Cerebral vasospasm and infarction

The following presents each of these problems in more detail and suggests appropriate methods for management currently in use at Grady Memorial Hospital and Emory University Hospital in Atlanta, Georgia, while awaiting the optimal time for definitive (intracranial) aneurysm surgery.

I. Intracerebral hematomas

While the majority of intracranial aneurysms rupture into the subarachnoid space, a small number will bleed directly into adjacent brain tissue with a resultant intracerebral hematoma, occasionally with extension into the ventricular system. These patients usually present with the acute onset of a significant focal neurologic deficit associated with signs of increased intracranial pressure, decreased level of consciousness and possibly meningismus. Patients who present solely with signs of a subarachnoid hemorrhage will manifest headache, stiff neck, frequent vomiting and photophobia and possibly depressed level of consciousness without focal neurological signs. In the former group of patients, immediate computer-assisted tomography (CAT scan) of the brain followed by cerebral angiography is indicated to demonstrate a surgically accessible hematoma which may require emergency evacuation. If the hematoma is large enough to cause uncontrollable increased intracranial pressure and possible transtentorial herniation, it should be evacuated immediately. If this is not the case, it would be desirable to wait the ten-day-to-two-week period discussed in the following pages prior to surgery.

In the absence of focal neurological deficit, the diagnosis of SAH should be confirmed and occasionally differentiated from meningitis, by a lumbar puncture. The cerebrospinal fluid (CSF) will usually be grossly bloody and may be distinguished from a traumatic puncture by immediately examining the supernatant fluid for xanthochromia. Once the diagnosis of a SAH has been made in this group of patients, cerebral angiography should be completed at the earliest convenient time. Modern neuroradiological techniques have made cerebral angiography a reasonably safe procedure and it is unlikely that it will increase cerebral vasospasm or cause rerupture of the aneurysm. The CAT scan is a suitable early substitute for angiography and adequately discloses the presence of intracerebral hematomas and hydrocephalus. However, cerebral angiography is the definitive diagnostic procedure to be performed prior to surgical therapy.

II. Increased intracranial pressure

An indirect indication of intracranial pressure can be obtained from the lumbar puncture. Although this is not always reliable, the opening and closing pressure measurements and the amount of fluid removed frequently reflect the size of the ventricular system (reservoir). When the initial pressure is elevated, it should be lowered to 150 mm CSF or one-half of the opening pressure, whichever is greater, by removing the appropriate amount of CSF. Lumbar puncture should not be performed in the presence of focal neurological signs or until an intracerebral hematoma has been ruled out with a CAT scan.

While awaiting the appropriate time for surgery, repeated lumbar punctures are indicated to relieve headaches and provide temporary relief from the symptoms of communicating hydrocephalus. Furthermore, one can follow the progressive clearing of the CSF, since it is our opinion that waiting for the CSF to clear prior to surgery decreases the risk of postoperative spasm. Corticosteroid therapy should be instituted with a lumbar puncture pressure greater than 300 mm of CSF, evidence of angiographic mass effect secondary to swelling or intracerebral

hematoma, or in the presence of papilledema. Methylprednisolone (Solu-Medrol) 20 mg QID or Dexamethasone (Decadron) 6 mg QID is recommended. This should be administered with an antacid to reduce the incidence of gastric hemorrhage.

III. Hydrocephalus

Hydrocephalus following subarachnoid hemorrhage is usually attributed to obstruction of the arachnoidal villi or the basal cisterns by an adhesive reaction to red blood cells in the CSF. The incidence ranges from 10 percent to 43 percent, depending on the series and the criteria for diagnosis. In one recent series, Yasargil and others reported 28 cases of hydrocephalus (10%) occurring in 280 ruptured aneurysms.[26] The condition may be present immediately following the SAH or may be delayed weeks or months. Diminished level of consciousness, impaired intellectual function, urinary incontinence and gait disturbances should suggest the possibility of hydrocephalus. Occasionally ventriculostomy with CSF drainage is necessary and five to ten percent of these patients will ultimately require a CSF shunting procedure.

IV. Rebleeding

An excellent review of the extensive literature on the incidence of rebleeding from intracranial aneurysms is available in Pakarinen's monograph.[22] Several series have reported an incidence of rebleeding within two weeks of the initial hemorrhage of greater than 30 percent with an associated mortality of ten to 25 percent.[14, 15]

Complete bedrest is indicated for at least four weeks, if no operative therapy is contemplated to reduce the likelihood of rebleeding. This period will obviously be less if surgery intervenes. Elastic support hose and leg exercises may prevent the formation of deep thrombophlebitis during this recumbent period. While at bedrest, careful monitoring of vital signs and neurological signs are imperative. Repeat subarachnoid hemorrhage is usually associated with transient systemic hypertension; whether this precedes the rebleed or is secondary to it is unknown.

Adequately sedating the patient avoids the agitation and worry that accompanies the preoperative waiting period and may reduce the incidence of rebleeding. Phenobarbital in a dose ranging from 45 to 60 mg four times a day is usually adequate and also acts as an anticonvulsant.

It is reasonable to assume that the greater the pressure gradient across the aneurysm wall, the greater the possibility of rupture. This assumption is confirmed by observations made at surgery when a red, thin-walled, pulsating aneurysm is less likely to rupture during dissection following the reduction of systemic arterial pressure by hypotensive anesthetic techniques. Slosberg introduced hypotensive therapy in 1956 for patients with ruptured aneurysms.[25] Antihypertensive therapy is indicated even in normotensive patients to avoid the blood pressure spikes associated with emotional stress and REM sleep. However, hypotension is to be avoided in the presence of cerebral vasospasm. Various medications may be used, but at present we prefer methyldopa (Aldomet) in doses ranging from 250 mg three times a day orally or intravenously to 3 gm per day if required. A thiazide diuretic is usually added to maintain adequate levels of hypotension. A mean arterial pressure in the range of 100 mm Hg is adequate.

Surgeons have been using antifibrinolytic therapy in states of abnormal fibrinolysis following open-heart surgery or massive generalized trauma for several years. Norlen in 1967 was the first to use antifibrinolytic therapy in an attempt to control hemorrhage not associated with abnormal fibrinolytic activity.[21] During excision of a cerebral arteriovenous malformation with bleeding uncontrolled by the usual hemostatic means, he administered epsilon-amino caproic acid (Amicar) intravenously, which was followed by prompt hemostasis.

Recent studies have confirmed the value of Amicar in decreasing the likelihood of rebleeding from ruptured aneurysms.[18, 24] Geronemus and others have recently reported a series of 34 patients with subarachnoid hemorrhage in whom antifibrinolytic therapy, in conjunction with corticosteroids, antihypertensives, and sedation lowered the incidence of rebleeding to 7 percent during the first two weeks following SAH.[10] A more recent controlled prospective study has demonstrated a decreased rebleed rate while awaiting surgery to 13 percent.[19] Amicar presumably acts to inhibit the elevated fibrinolytic activity present following SAH at the rupture site on the aneurysm dome and increases the persistence of the fibrin plug to prevent rebleeding. Amicar is administered in a dosage of 48 gm per day, preferably as a continuous intravenous drip, although it may also be administered orally. Because it is rapidly excreted, Amicar should be given intermittently at intervals no greater than two hours.[16] There are no associated serious side effects. CSF fibrinolytic activity may be monitored to assure adequate dosage.

V. Spasm

Many technically excellent surgical procedures have yielded poor results because of the onset of cerebral vasospasm in the postoperative period with associated cerebral ischemia and possibly infarction. Cerebral vasospasm typically presents with a biphasic time curve. The early phase occurs within 48 hours following the subarachnoid hemorrhage with the peak of the delayed phase eight to ten days fol-

lowing aneurysm rupture. Either the early or delayed form of vasospasm may be seen in the postoperative period following aneurysm surgery. Multiple theories regarding the etiology of vasospasm have been proposed and numerous spasmogenic factors in blood and platelets incriminated.

To diminish the likelihood of postoperative vasospasm, it is necessary to wait until the "vascular susceptibility" to operative manipulation has passed. Aneurysm surgery should be delayed until the patient's neurological status is completely stabilized, the CSF has cleared and no evidence of persistent spasm is seen on repeat angiography. This may take two to three weeks. However, with the use of the measures previously outlined to reduce the incidence of rebleeding in the period prior to surgery, one can more securely await the required time necessary to avoid the dangers of cerebral vasospasm.

In a recent clinical trial at Grady Memorial Hospital treating cerebral vasospasm, we have used a combination of Isuprel and Aminophilline. These drugs have been shown to increase tissue levels of cyclic AMP which is necessary for the normal functioning of vascular smooth muscle and have been demonstrated effective in laboratory animals and in another small series of patients.[7, 8, 12] Aminophilline is administered initially in a dose of 250 mg intravenously over 15 minutes, then 125 mg/hr thereafter. Isuprel is administered in a dosage of 125 μg/hr. It is essential to monitor the patient closely for tachycardia and arrythmias which may necessitate lowering the dosages. Evaluation of this therapy at Grady Memorial Hospital has demonstrated a good response in seven of 13 patients treated. Other promising spasm therapy includes the use of Nitroprusside and a hypertensive agent in combination to avoid the hypotensive effects of Nitroprusside which is a smooth muscle relaxant.[1, 11]

With the recent advances in surgical techniques for cerebral aneurysms, the operative mortality and morbidity figures have been dramatically reduced in properly selected patients to less than 1 percent in some series.[9] Thus, the goal of the preoperative management is to protect and maintain the patient without rebleeding until that time when the risk of postoperative cerebral vasospasm is lowest, with the ultimate therapy being direct surgical obliteration of the aneurysm.

REFERENCES

1. Allen, G. S.: "Cerebral arterial spasm—Part 8," *Surg. Neurol.*, 6:71-80, 1976.
2. Botterell, E. H., Lougheed, W. M., Morley, T. P. et al: "Hypothermia in the surgical treatment of ruptured intracranial aneurysms," *J. Neurosurg.*, 15:4-18, 1958.
3. Dandy, W. E.: "Intracranial aneurysm of the internal carotid artery," *Ann. Surg.*, 107:654-659, 1938.
4. Dott, N. W.: "Intracranial aneurysms: cerebral arterio-radiography: surgical treatment," *Edinburgh Med. J.*, 40:219-234, 1927.
5. Drake, C. G.: Discussion of Hunt, W. E., Hess, R. M.: "Risk related to time of surgery in intracranial aneurysms," *J. Neurosurg.*, 28:19-20, 1968.
6. Ecker, A., Riemenschneider, P. A.: "Arteriographic demonstration of spasm of the intracranial arteries with special reference to saccular arterial aneurysms," *J. Neurosurg.*, 8:348-353, 1951.
7. Flamm, E. S. and Ransohoff, J.: "Treatment of cerebral vasospasm by control of cyclic adenosine monophosphate," *Surg. Neurol.* 6:223-226, 1976.
8. Flamm, E. S., Viau, A. T., Ransohoff, J.: "Experimental alterations in cyclic adenosine monophosphate concentrations in the cat basilar artery," *Neurology*, 26(7):666, 1976.
9. Fox, J. L., Yasargil, G. M.: "The microsurgical approach to intracranial aneurysms," *Surg. Neurol.*, 3:7-14, 1975.
10. Geronemus, R., Herz, D. A., Shulman, K.: "Streptokinase clot lysis time in patients with ruptured intracranial aneurysms," *J. Neurosurg.*, 40:499-503, 1974.
11. Heros, R. C., Zervas, N. T., Lavyne, M. N. and Pickinen, K.: "Reversal of experimental cerebral vasospasm by intravenous nitroprusside therapy," *Surg. Neurol.*, 6:227-229, 1976.
12. Kim, K., Flamm, E. S., Lin, J.: "Experimental cerebral vasospasm and cyclic adenosine monophosphate (cAMP)," *Invest. Radiol.*, 10(3):239-243, 1975.
13. Locksley, H. B.: "Natural History of Subarachnoid Hemorrhage, Intracranial Aneurysms, and Arteriovenous Malformation," in Sahs, A. L., Perret, G. E., Locksley, H. B. et al (eds): *Intracranial Aneurysms and Subarachnoid Hemorrhage,* Philadelphia, J. B. Lippincott, 1969, pp. 68-82.
14. Logue, V.: "Surgery in spontaneous subarachnoid hemorrhage. Operative treatment of aneurysms of the anterior cerebral artery and anterior communicating artery," *Brit. Med. J.*, 1:473-479, 1956.
15. McKissock, W., Richardson, A., Walsh, L. S.: "Middle cerebral aneurysms: Further results in the controlled trial of conservative and surgical treatment of ruptured intracranial aneurysms," *Lancet*, 2:417-421, 1962.
16. McMichal, G. P., Fletcher, A. P., Alkjaersid, N. et al: "The absorption, distribution, and excretion of ϵ-aminocaproic acid following oral or intravenous administration to man," *J. Lab Clin. Med.*, 59:15-24, 1962.
17. Moniz, E.: "L 'encephalographie arterielle, son importance dans la localisation des tumeurs cerebrales," *Rev. Neurol.*, (Paris) 2:72-89, 1927.
18. Mullan, S., Dawley, J.: "Antifibrinolytic therapy for intracranial aneurysms," *J. Neurosurg.*, 28:21-23, 1968.
19. Nibbelink, D. W., Torner, J. C. and Henderson, W. G.: "Intracranial aneurysms and subarachnoid hemorrhage. A cooperative study. Angiographic therapy in recent onset subarachnoid hemorrhage," *Stroke*, 6:622, 1975.
20. Norlen, G., Olivecrona, H.: "The treatment of aneurysms of the circle of Willis," *J. Neurosurg.*, 10:404-415, 1953.
21. Norlen, G., Thulin, C. A.: "Experiences with epsilon-aminocaproic acid in neurosurgery: a preliminary report," *Neurochirurgia* (Stuttgart), 10:81-86, 1967.
22. Pakarinen, S.: "Incidence, aetiology, and prognosis of primary subarachnoid hemorrhage: A study based on 589 cases diagnosed in a defined urban population during a defined period," *Acta Neurol. Scan.*, 43 (suppl. 29):1-128, 1967.
23. Pool, J. L.: "Cerebral vasospasm," *New Eng. J. Med.*, 259:1259-1264, 1958.
24. Ransohoff, J., Goodgold, A., Benjamin, M.: "Preoperative management of patients with ruptured intracranial aneurysms," *J. Neurosurg.*, 36:525-530, 1972.
25. Slosberg, P. S.: "Hypotensive therapy in acute intracranial bleeding," *J. Mount Sinai Hosp. NY*, 23:825-831, 1956.
26. Yasargil, M. G., Yonekama, Y., Zumstein, B., Stahl, H. J.: "Hydrocephalus following spontaneous subarachnoid hemorrhage," *J. Neurosurg.*, 39:474-479, 1973.

MAG Self-Funded Trust

Report of the Membership Insurance Committee, Perrin Nicholson, Chairman

JOHN T. MAULDIN, M.D., *Atlanta**

MAG IS INVESTIGATING the possibility of utilizing a Self-Funded Health Trust as a service to its membership. The purpose would be to save money for the membership and employees, primarily in hospital and medical insurance, and to deal with insurance companies in other types of insurance on a more equitable basis. Savings from 15 percent to 35 percent may be obtained in hospital and medical insurance, depending on the program.

What Is Self-Funding?

Self-funding is not a new concept, but is receiving increasing attention as a mechanism for health care benefit programs. Should an employer say to his employees, "Bring me your medical bills and I will pay them," this would be pure self-funding. The employer would then establish a fund that would be actuarially sound (see Spreading the Risk). The employer would then pay the medical bills from this fund and replenish the fund as necessary. An employer may accomplish this in many ways. Most often, he will opt to accept part of the risk and buy insurance for the rest. Should he desire, he may insure a part of his risk with excess loss insurance.

This can be best illustrated by a hypothetical example. Suppose a program was set up to have $100.00 deductible, 80 percent co-insurance up to $2,000.00, and pay all costs over $2,000.00 to a maximum of $250,000.00 per life time. Also, assume that the employee contributes $10.00 a month to this program. Should an eligible individual have claims of $5,000.00, the responsibility would be divided as follows:

$ 100.00 Deductible	**Employee's responsibility**
$ 380.00 20% of $1,900.00	**Employee's responsibility**
$ 120.00 Monthly contribution	**Employee's responsibility (one year at $10.00 per month)**
$ 600.00 Total of employee's responsibility	
$1,400.00 (See Spreading the Risk)	**Employer's responsibility**
$3,000.00 Major Medical	**Insurance company's responsibility**
$5,000.00 Total expenses	

* Suite 528, 315 Blvd., N.E., Atlanta, Ga. 30312.

Spreading the Risk

Assume that an employer has one hundred employees or that the Trust has one hundred members. Now assume that during any one covered period, 20 percent of the members could be expected to have claims of $5,000.00. The Trust/Employer responsibility would be 20 times $1,400.00 or $28,000.00. This would result in a premium cost of $23.33 per month. This situation has never occurred, but should all 100 members have costs of $5,000.00, the Employee/Trust cost would then be $1,400.00 times 100 or $140,000.00. The premium cost would then be $116.60 per month, instead of $23.33 as could be expected under normal circumstances. This illustrates the savings that usually result when using a relatively large number of individuals to spread the risk. It must be emphasized that these figures are for illustration only and are not actuarially sound. Neither do they represent total cost. There would still remain the additional cost of administration. This additional cost would be approximately 20 percent of premium divided as follows: 10 percent for administration, 2 percent to 4 percent for excess loss insurance, and 5 percent for acquisition costs.

Excess Loss Insurance

Excess loss insurance is that type of insurance that would pay all losses above an agreed-upon amount. Now, by quickly reviewing the example given above, an Employer/Trust of one hundred people would expect to pay $28,000.00, but might very remotely be liable for $140,000.00. Should the Employer/Trust be unwilling to accept this total risk, he may purchase excess loss insurance beginning at some point above premium, $28,000.00. This pick-up point for stop-loss insurance may vary from 105 percent to 200 percent of total paid premium.

Trust

The formation of a Trust is best if an employer accepts employee contributions to avoid the inference of functioning as an insurance company. In the

case of multiple employers, as in an association, a trust is necessary.

In 1964, the Monsanto Company developed a self-funded plan with minimal premium arrangements with Metropolitan Life. The State Insurance Commissioner of Missouri sued to enjoin Monsanto from engaging in the business of insurance. The case went to the State Supreme Court and that Court held that providing benefits to employees does not constitute the transaction of insurance business. This decision cleared the air from the insurance standpoint.

Section 514(B)(2) of ERISA preempts states from regulating self-funded plans under insurance banking and investment laws. This apparently removed any legal barrier to full self-funding. Several states have accepted this ruling, but at the present time in Georgia, the situation on health benefit trust is not completely clear, although the state employees are self-insured.

Benefits of Self-Funding

1. Based on the experience of the other organizations who have formed a health benefit trust of employees and have chosen self-insurance, savings usually range between 15 percent and 35 percent depending on the program. An actual example is given below.

2. Reserves: Any interest that may accumulate from reserves or other available moneys goes into the Trust instead of being lost to an insurance company.

3. Claims control procedure: This is a very important factor in keeping costs down. The Association could establish its own policies and procedures on a fair and equitable basis. An appeal mechanism could be a part of the program, if desired. Also, the benefit package would be determined by the Association. When dealing with an insurance company, a previously tailored benefit package usually has to be accepted or rejected in toto.

4. Administration: The administration includes a number of operations: processing and payment of claims, maintenance of necessary records, accountability of funds, administration of the Trust, and advice and related actuarial information necessary to the proper maintenance of the Trust.

5. Acquisition costs: This is probably the most important ingredient, simply because without member participation, there can not be a program. This also is a cost that the Association would have that an employer would not, because our members would be scattered all over the state, while an employers' members would be in one location.

It is my belief that the administration can be more flexible and responsive when performed by an organization specifically designed for this purpose.

6. Premium tax: At this time, there is a 2 percent premium tax paid to the State of Georgia by all insurance companies. This tax is not required of a Trust.

The premium of an actual program can not be presented at this time, because a Trust must first be established. Therefore, the actual figures from two programs will be presented below. These programs were not singled out from a number of programs, but are the *only* programs for which accurate figures were available to me at this time. It may be of value to compare these figures with those of your present program.

PROGRAM I

Basic benefits: Hospital room and board limit $60.00 per day for 60 days
Surgical expenses: Up to $1,000.00
Medical benefits: $10.00 per day for 30 days
Laboratory and X ray: Limit $200.00
Major Medical Benefits: Maximum $250,000.00 per lifetime, deductible $100.00, co-insurance 80%-20% on the first $5,000.00, then 100% of remaining

Costs

$187,455.58	Cost of insurance premium when not self-insured
$109,986.19	Total self-insurance for one year
$77,459.39	Savings—43%
283	Average number of insured
$55.19	Average insurance premium
$32.38	Average self-insurance premium

PROGRAM II

Basic benefits:
Surgical: Up to $1,000.00, based on 1964 RVS unit $5.00
X ray and Lab: $10.00 deductible up to $100.00
Excess charges in both eligible for Major Medical
Major Medical Benefits:
$100.00 deductible per year (maximum 4 deductibles per family)
80%-20% co-insurance to maximum of $250,000.00 per lifetime
Psychiatric—80% to maximum of $30.00 per treatment to a maximum of $1,600.00 per year

Costs

$411,621.00	Cost of insurance premium when not self-insured
$283,537.92	Total self-insurance cost
$128,083.03	Saving—31%
680	Average number insured
$50.44	Average insurance premium
$34.74	Average self-insured premium

The cost of self-insurance for MAG members would be slightly higher because of acquisitions costs. However, the saving would still be quite substantial. Life and disability benefits could be included in the program through arrangements with an insurance company.

It is recommended that the Executive Committee be instructed to form a Health Benefit Trust for the benefit of MAG members.

Editor's note: Let us know what you think.

HARRISON L. ROGERS



THE MEDICAL ASSOCIATION of Georgia is pleased to have one of its members as a candidate for office in the American Medical Association. At the 1977 Clinical Convention in San Francisco, MAG will enter the name of Harrison L. Rogers, M.D., for the position of Vice Speaker of the House of Delegates of the AMA.

Dr. Rogers has demonstrated his ability many times as a strong and competent leader. MAG is confident that he will be a tremendous asset to the national medical federation.

A Fellow in the American College of Surgeons and certified for the American Board of Surgery, Dr. Rogers has been in private practice as a surgeon since 1957. He is on the active staff of Crawford W. Long Hospital, Piedmont Hospital and St. Joseph's Infirmary, in addition to being on the courtesy staff of West Paces Ferry and Doctors Memorial Hospitals.

He is Chairman of the National Legislative Committee, the Cost Accountability Committee and the Joint Hospital Survey Committee of MAG; Chairman of the Georgia Delegation to the AMA House of Delegates; Treasurer of the Georgia Chapter of the American College of Surgeons, and Regional Delegate to the House of Delegates of the American Hospital Association.

His past record includes serving six years as Speaker of the House of Delegates of MAG, after first serving five years as Vice Speaker. In 1973, he was President of the Medical Association of Atlanta.

He has been on the Board of Directors of the American Red Cross and Treasurer and member of the Board of Atlanta Blue Shield.

MAG is proud to support such a distinguished physician with such an outstanding record. Our best wishes to him for a successful campaign and an effective term as Vice Speaker of the AMA.

editorials
editorials
editorials

HSAs: Black Hats or White Hats?

IN THIS ISSUE on page 141, Robert A. Youngerman, Executive Director of the North Central Georgia Health Systems Agency (NCG-HSA), reviews the progress in implementing P.L. 93-641 in Georgia, with special attention given to activities underway in the 24-county North Central Georgia area surrounding Atlanta.

Many of us in the medical profession are aware of various features of P.L. 93-641 that have given us cause for concern regarding future involvement of the federal government in the practice of medicine. This concern has manifested itself in a number of way, including a lawsuit filed by AMA contesting the constitutionality of the Act. Furthermore, I have discussed with many colleagues from other states how the medical profession is being systematically excluded from participation on the Boards of HSAs around the country.

All of the above is true, and there is little doubt that the health planning mechanism established by P.L. 93-641 at the state and areawide levels gives the HSAs and the state additional "clout" in health affairs. However, a couple of important distinctions should be made regarding the situation in Georgia as compared with that in other states. First, physicians are involved in the HSAs in Georgia. They are represented on the HSA Boards in an equitable number, considering the legal requirements for board composition. By no mean do physicians dominate the HSA Boards in Georgia, but the medical viewpoint is being heard and is being given careful consideration, along with the viewpoints of many others.

Secondly, the physicians on the HSA Boards have informed me that they have found the diverse views represented on these Boards to be valuable in obtaining a greater sensitivity to the concerns expressed in the communities regarding health problems, and this permits physicians to be more responsive to community needs.

As Mr. Youngerman states in his article, no one can argue with the goal of improving accessibility to care and availability of care at a reasonable cost. Physicians are for that as much as other members of society. Further, nobody is in favor of wasteful duplication of facilities and services, especially physicians.

The HSAs, by law, must address these issues. Who knows if they will be successful? But right now they are where the action is, and if they are successful, the medical profession needs to be involved. In Georgia, I believe we are.

Harrison L. Rogers Jr., M.D.
1938 Peachtree Road, N.W., Suite 601
Atlanta, Georgia 30309

Medical Costs: Why Not a Speakers Bureau?

DURING THE EARLY PHASES of Medicare and Medicaid, the main thrust taken was to make quality medical care available to the aged and the indigent. Now it would appear that cost containment—at all costs—is the main thrust of third-party providers.

As could have been anticipated, these providers now point their fingers at the medical profession as the group who is ultimately responsible for the rise in medical costs. The media have done their predictable bit to fan the flames of discontent, and many politicians have joined in the chorus.

Anyone who surveys the facts will realize that physicians' fees represent only about 17% of the health care dollar and that the rate of rise in professional fees across the board in the past 20 years has been less than half the rise in hospital and other associated costs. The price of consumer goods and especially medical supplies has risen at a much more rapid rate than professional fees have. Hospital fees are of necessity raised by the fact that they are required by law to accept assignment for Medicare and Medicaid patients' fees. How many patients recognize this fact? Probably less than 1%. Modern, well-equipped hospitals would probably become bankrupt if they could not adjust their fees upward to compensate for the deficit produced by Medicare and Medicaid patients. Wage and hiring regulations further complicate the problem.

We have written press releases describing these inequities, but we know from repeated experience that the press and other media have no inclination to publicize these facts. It would seem that we could take a lesson from President Carter and his phenomenal campaign: we can—and should—take our message directly to the people. This could be done by setting up speakers bureaus through our county and state medical societies. Physicians could be provided with excellent talks on medical costs—prepared by the Medical Association of Georgia. These prepared talks could be delivered before civic clubs and other interested organizations. Other state medical associations could sponsor comparable programs.

If we fail to explain the facts about medical costs to the American people, certainly nobody else will. Your local civic club members are anxious to hear the truth.

Edgar Woody, Jr., M.D.
Editor

I've told this before . . . .

(Editor's note: A Navy lieutenant has quite an experience in this story shared by J. G. McDaniel. Your contributions to this column are invited. Contact the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309; Telephone (404) 876-7535.)*

Navy Lieutenant on a Train

DR. TOM GOODWIN of Augusta, Georgia, tells an interesting story that happened to a young Navy lieutenant back during World War II.

This lieutenant was youngish, nice looking, well educated and attached to Intelligence. Because of this fact, some of his assignments required that he dress in civilian clothes. He had been on such a mission on the West Coast and was returning via train to New York to make his report. This was in 1943 when all air and train travel was over-crowded and running behind schedule, and citizens were being bumped right and left by higher military or government officials—so much so, that you had to be pretty much of a "somebody" to have any kind of an approach to first class accommodations.

Just at dusk, as his train was pulling out of Cincinnati, he went to the club car to have a wee modicum of spirits before dinner. The day had been long and tiring, his report had been completed and typed. As was to be expected, the club car was crowded and the only vacant seat was at a table for two, across from a lady. When he asked her if he might sit there, he liked her ready smile and the tone of her voice when she said, "certainly."

She was sipping on an Old Fashioned, which looked good and when asked, she recommended it. Later on they introduced themselves. She was "Nanette" something-or-other. He did not catch her last name, but at this time it did not matter too much. He just remarked that he had always liked the name Nanette, but especially since the musical comedy "No, No, Nanette" had become so popular. It seemed that she liked it also and knew its composer, Vincent Youmans, fairly well.

The more they talked, the better he liked her. She was a blue-eyed brunette, poised, conservatively well clad, mature twentyish and well educated.

They ate dinner together, then went back to the club car for after-dinner liquors. Each seemed to develop a great admiration for the other. They "hit it off well," so much so that they were among the last to leave the club car. As they left, she said she hated to go back to her drawing room following such an enjoyable evening. He asked how far down she was. Her reply, "In the fifth car down, Gladys, #A drawing room," and they bid goodbyes and parted.

He undressed and went to bed, but welcome sleep would not come to a weary body and tired eyes. All he could think of was Nanette and her blue eyes. Even the rails and the wheels sang a song, "Five cars down, drawing room A, five cars down, drawing room A." After about an hour of tossing and turning, he got up, put on his shoes and robe and walked through the twisting, darkened train to the fifth car down, found Gladys, knocked gently on the door of drawing room A.

When she opened the door, she looked more stunning than ever. All she said was, "I'm so glad you came. I just knew you would."

After some little time, they both inadvertently dropped off into a peaceful sleep. He was awakened suddenly because the train noise and motion had ceased. He reached over her and raised the shade. It was dawn and it looked as if they were

in a railroad yard. She roused up and looked out. "Oh, we're home," she said. "And where's home?" he inquired. "Baltimore," she said.

He jumped out of bed, slipped on his shoes and robe and found the porter, who told him that this was the Baltimore car that had been switched off and the rest of the train was just fading up the track on the way to New York. "But you don't have to get up now, boss. Dey don't move dis car 'till about 10 o'clock . . . you go on back to bed and finish yo' rest."

A gloomy, dejected Navy lieutenant walked slowly back to drawing room A. Here he was in Baltimore, no identification, no money, no clothes, no briefcase. All sorts of things flashed through his mind, like charges of conduct unbecoming an officer, neglect of duty, skylarking and, if his confidential papers should fall into unscrupulous hands, even court martial. Of course, he had locked his bedroom door and had the key in his pocket . . . a little consolation as he fingered it like a nun would her rosary.

When he returned to her room, Nanette was dressed and doing her face and hair. She took command now, asked him the measurements of his waist, length of his trousers, etc., gave him some magazines, told him not to worry. She put one hand on each cheek, puckered his mouth, gave him a big smackaroo and said that she'd be back at 9:30.

She returned, bringing a good-sized paper box. In this box was a seersucker suit that fit him, a belt, shirt, blue tie, shorts, socks and a comb. After he had dressed in his new outfit, he felt and looked better. Then she handed him an envelope that contained $50. She refused to give him any address, nor even her last name. She simply threw her arms around him, kissed him soundly as though she meant it, and was gone before he could comb his hair.

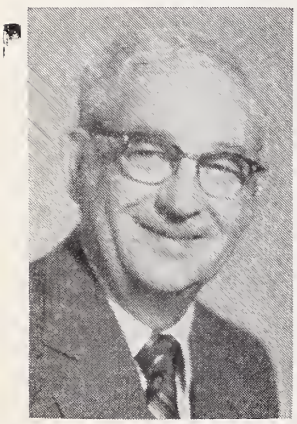
As happens so many times, the sun comes out after the cloudiest morning. He got a ticket in the chair car on the next train to New York. The train master in Baltimore called his fellow worker in New York, explained the situation, and from what he overheard of the conversation, this was not an earth-shaking event to them, but rather "old hat." He recovered his gear in New York, called his commanding officer and told him that he had been delayed in Baltimore, which was just as well said the executive officer, because they would not need his report until the next morning.

When he was telling Tom this story, it was at the close of the war, he was now a full commander and when he finished his story, he took out his wallet, and pulled from a secret compartment an old, stained 100 dollar bill. Across the top was written, "Nanette," but the name had faded a little from sweat and seawater. "I've searched and searched for her," said he. "The truth is, nothing in the world I'd rather do or could make me any happier than to put this bill in Nanette's hand."

His listeners cast dubious glances at each other, but said nothing, since it is accepted by old salts that in affairs of this kind, even commanders are forgiven for sometimes taking liberties with the whole truth.

J. G. McDaniel, M.D.
820 W. Wesley Rd., N.W.
Atlanta, Ga. 30327

president's letter



Some Closing Remarks

THIS HAS BEEN a rewarding year for Anne and me. Anne has taken the brunt of many evenings away from home for various meetings. The weekends have been punctured too by meetings. I believe the wives of the husbands who give of their time to this organization and other medical organizational activities are the dedicated ones, not us physicians. So, I pay tribute to Anne and the other "widows"—Mary, Bunny, Jackie, Jeff, Mary Ellen, Alice Carrol, etc.

For eating places in Atlanta, may I suggest the Farmers Market and, in Savannah, the Seventeen Hundred and Ninety.

Guess we might sum it up this way. Doctors wish to be left alone, do their own thing, and let someone else "do it."

April will bring the new author, Bob Perry, for the *President's Letter*. Please treat him as nicely as you have treated me.

It's been fun meeting you folks, and my regret is that I didn't get into every society—but then some of you don't meet too often. Too, I think you will find the officers of this society willing to visit a bit more eagerly when asked.

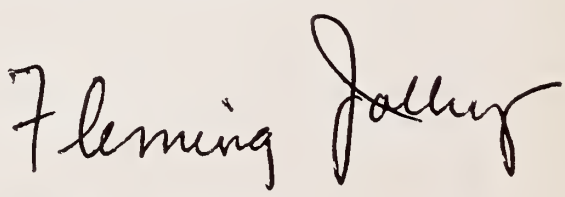
Now, for part three of the survey.

1. What are your thoughts on quarterly meetings of the House of Delegates to replace Council meetings?
2. Do you feel specialty societies should have separate voting representation in the House of Delegates?
3. How would you feel about specialty societies having a more meaningful role in continuing medical education for MAG?
4. How would you encourage total membership of the practicing physicians in the MAG?
5. Would you be in favor of discontinuing the *Journal of MAG?* What changes would you like to see in the *Journal?*
6. How can the MAG Scientific Session be more meaningful to you?
7. Has Medicaid improved in payment and service in the past three months?

I shall have a *Journal* report to you in the near future on these results.

My sincere thanks to each of you for your support during the past year, and best of luck in years to come. MAG will be what you make it.

Sincerely and respectfully,



Fleming L. Jolley, M.D.
President, Medical Association of Georgia

Testing Stool for Occult Blood to Detect Asymptomatic Large Bowel Cancer

MARIO J. R. RAVRY, M.D., *Atlanta**

OVER 100,000 AMERICANS will develop large bowel cancer in 1977, and more than 48,000 will die from this form of cancer. It has been estimated that everyone in this country has a 1-in-25 chance of developing colorectal cancer in his lifetime.[1] Surgery is the only form of therapy with curative potential for large bowel cancer. Yet, at the time of diagnosis, approximately 60 percent of large bowel cancers are beyond the localized stage and have at least lymph node involvement,[1] decreasing significantly the patient's chances for five-year survival.

In spite of advances in surgical technique, mortality from large bowel cancer has not been altered significantly in the past 30 years. On the other hand, most patients in whom large bowel cancer is in an asymptomatic stage have localized disease and their five-year survival approaches 90 percent.[1] It is clear, therefore, that our only hope of providing more large bowel cancer patients with a cancer cure is to make an earlier diagnosis, preferably in the asymptomatic stage.

Techniques for Detection

Multiple techniques are presently available which are of definite value for the diagnosis of large bowel cancer: Proctosigmoidoscopy, barium enema, colonoscopy, colonic cytology, the carcinoembryonic antigen (CEA), and tests for fecal occult blood.[1] The relative expense, and requirements for extended time, trained personnel, and instrumentation of the first four techniques make them impractical for the screening of asymptomatic large bowel cancer. The CEA test, once hoped to be the long-awaited screening test for large bowel cancer, has been shown to be nonspecific for large bowel cancer and unsuitable for screening purposes. Only the tests for fecal occult blood, by virtue of their simplicity, relative specificity, ease of performance, and relative inexpensiveness, appear to be acceptable for widespread detection of asymptomatic large bowel cancer.

Tests for Fecal Occult Blood

Although there are various methods available for the detection of fecal occult blood,[2] only the chemical tests fulfill the above mentioned requirements for a

* Chairman, Subcommittee on Professional Education for Physicians, American Cancer Society, Atlanta City Unit; Clinical Assistant Professor of Medicine, Emory University School of Medicine. Dr. Ravry's address is 478 Peachtree St., N.E., Atlanta, Ga. 30308.

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

widely applicable screening test. The chemical tests are based on the oxidation of a phenolic compound to a quinone structure which by an intermolecular reaction yields a blue dye. The oxidation reaction is facilitated by hydrogen peroxide and can be catalyzed by many substances, particularly the peroxidases which contain a heme-like moiety. One source of peroxidase enzymatic activity is hemoglobin. It is beyond the scope of this paper to describe in detail the various chemical tests, but this subject has been well reviewed by Irons and Kirsner.[2]

Ostrow and associates,[3] evaluated the sensitivity and reproducibility of two standard guaiac methods, the orthotolidine tablet test (Hematest), and the guaiac slide test (Hemoccult: Smith, Kline and French Laboratories, Philadelphia, Pa.). The standard guaiac and the orthotolidine tests frequently detected concentrations of 2.0 mg. hemoglobin/gm. of stool, while Hemoccult detected concentrations greater than 5 mg. hemoglobin/gm. of stool. Although Hemoccult proved to be less sensitive than the other tests in detecting occult blood, it produced a false-positive reaction in only 1 percent of the specimens tested compared to 27 percent to 49 percent with the other tests. Recent reports suggest that the rate of false-positive reactions may be closer to 10 percent with Hemoccult but greater than 70 percent with the standard guaiac test and Hematest.[4] Furthermore, the Hemoccult test is highly reproducible (96 percent), even at the lowest intensities of reaction, with the results of the other tests being reproducible in only 70 to 86 percent of the cases and producing disagreements at low intensities of reaction.[3]

Should the physician use a more sensitive test (standard guaiac, Hematest), in spite of the higher number of false-positive reactions and the need to test further for confirmation of results, or should he use a less sensitive and more accurate test (Hemoccult), even at the risk of failure to detect smaller concentrations of occult blood? Subsequent evaluation of positive reactors to the more sensitive tests has shown that up to 50 percent had no lesions found at subsequent endoscopic and radiologic examinations.[2, 3, 5] However, 80 percent of the patients giving a positive Hemoccult test have been found to have a large bowel lesion on subsequent testing.[5] Twenty percent of those patients giving a positive reaction had a large bowel carcinoma and another 20 percent had polyps, a probable percursor of large bowel cancer. Furthermore, radioisotopic studies using 51 Cr-labeled red cells indicate that in spite of daily fluctuations, the rate of bleeding from gastrointestinal lesions is usually within the range detected by Hemoccult.[3, 6] Therefore, it appears that Hemoccult would be a relatively sensitive, reproducible, and dependable test for the screening of asymptomatic large bowel cancer.

The Hemoccult Method

The Hemoccult method is based on the guaiac reaction.[7] Natural guaiac resin is impregnated into filter paper through which a stool specimen is applied. The slide can either be tested or preserved in its container for later testing by the addition of a stabilized hydrogen peroxide-denatured alcohol developing solution.

The rate of positivity for Hemoccult, as with other tests, varies with the rate of blood loss and concentration of hemoglobin in the stool.[6] False-positive reactions can be produced by multiple factors, among which is the diet. Meats have been shown to produce a false-positive reaction because of their peroxidase content.[8] As a result, elimination of meat from the diet has been advocated before and during Hemoccult testing.[5] Ostrow and associates, however, found little decrease in the frequency of false-positive reactions by elimination of meat.[3] Also, it is said that a meat-free diet will decrease patient compliance with the program. On the other hand, Winawer believes that elimination of meat from the diet could still be of importance in large screening programs, because of the number of people requiring subsequent unnecessary investigation with more complex techniques.[4, 5]

False-negative reactions have been reported to occur in 2 percent of the specimens in one series,[3] and in 40 percent of the specimens in another.[9] These reactions may be the result of low hemoglobin concentrations in the tested stool, or of

the intermittent nature of bleeding from intestinal lesions. Recent studies have called attention to the fact that storage of samples in Hemoccult slides with delayed testing may be the single most frequent cause of false-negative results. False-negativity rates as high as 40 percent have been reported in specimens tested after only four days of storage.[9] This is particularly important in specimens which have a low hemoglobin concentration. Vitamin C in large amounts may also produce false-negative results, even in the presence of significant amounts of blood.[10] Barium has been shown not to interfere with the performance of the Hemoccult.[11] Iron and laxative ingestion, contrary to previous beliefs, seem to reduce the number of both false-positive and false-negative reactions.[11]

The Greegor Method

Realizing the limitations of testing a single stool specimen, Greegor suggested and demonstrated that testing six stool slides from three consecutive daily bowel movements increased the chance of obtaining at least one positive test.[5] The method was tested while patients were on an unrestricted diet, but almost one out of every four patients had a positive test, which in one-half of the patients was associated with no colon abnormalities on subsequent investigation. When examinees were required to be on a meat-free (to decrease the frequency of false-positive reactions), high residue (to irritate lesions which bleed intermittently and increase bleeding) diet throughout the four days of testing, the frequency of positive reactions was reduced to one out of every twenty patients, and four patients out of every five positive reactors had a large bowel lesion.

The Approach

1. All potential examinees should be placed on a meat-free, high residue diet for at least 24 hours before the first stool specimen is collected, and should continue on it for the next three days during which the stool is collected. The diet should:
   (a) Be free of beef, fish or chicken
   (b) Contain abundant residue in the form of raw and cooked vegetables (lettuce, carrots, spinach, corn, etc.), fruits (prunes, grapes, apples, etc.) and some form of bran cereal. There should be at least two daily servings of vegetables and fruits.
   (c) Contain moderate amounts of peanuts and popcorn daily.
2. All potential sources of Vitamin C and of gastric irritants such as salicylates, indomethacin, and phenylbutazone, should be discontinued. Iron and laxatives have no effect on the testing. Ideally, Hemoccult should be done prior to any barium contrast study.
3. Each of the two daily stool samples should be taken from the two opposite portions of the same stool specimen.
4. All slides should be tested as soon as possible, preferably within two and certainly no later than four days after preparation. Storage and mailing should be discouraged whenever possible.
5. Any patient having at least one positive test (regardless of whether the reaction is weak or strong) warrants further aggressive investigation with proctosigmoidoscopy, barium enema (preferably with air contrast technique), and colonoscopy. If the large bowel is normal, the proximal gastrointestinal tract should be thoroughly investigated for a bleeding lesion.

Summary

The aim of this program is to detect colon cancer in the asymptomatic patient, by the use of a simple and relatively inexpensive technique which is applicable not only to the single patient but also to widespread screening. Although Hemoccult is used daily across the United States, it is infrequently used in the manner prescribed above. The method described herein utilizes a rational approach for the detection

of bleeding from asymptomatic colon lesions, while attempting to minimize false-positive and false-negative results. While polyps may be detected more frequently than carcinomas[5] by this approach, it does not detract from the success of the program, since there is evidence to suggest that removal of these polyps may result in a lower incidence of large bowel cancer in the population.[12]

REFERENCES

1. Winawer, S. J., Sherlock, P., Schottenfeld, D. et al.: "Screening for colon cancer," *Gastroenterol.* 70:783-789, 1976.
2. Irons, G. V., Jr. and Kirsner, J. B.: "Routine chemical tests of the stool for occult blood: An evaluation," *Am. J. Med. Sci.* 249:247-260, 1965.
3. Ostrow, J. D., Mulvaney, C. A., Hansell, J. R. et al.: "Sensitivity and reproducibility of chemical tests for fecal occult blood with an emphasis on false-positive reactions," *Am. J. Dig. Dis.* 18:930-940, 1973.
4. Winawer, S. J.: "Fecal occult blood testing," *Am. J. Dig. Dis.* 21:885-888, 1976.
5. Greegor, D. H.: "Occult blood testing for detection of asymptomatic colon cancer," *Cancer* 28:131-134, 1971.
6. Stroehlein, J. R., Fairbanks, V. F., McGill, D. B. et al.: "Hemoccult detection of fecal occult blood quantitated by radioassay," *Am. J. Dig. Dis.* 21:841-844, 1976.
7. Product Instructions: "Hemoccult® Slides and Tape." Philadelphia, Smith, Kline & French Diagnostics, August, 1974.
8. Illingworth, D. G.: "Influence of diet on occult blood tests," *Gut* 6:595-598, 1965.
9. Stroehlein, J. R., Fairbanks, V. F., Go, V. L. W. et al.: "Hemoccult stool tests: false-negative results due to storage of specimens," *Mayo Clin. Proc.* 51:548-552, 1976.
10. Jaffe, R. M., Kasten, B., Young, D. S. et al.: "False-negative stool occult blood tests caused by ingestion of ascorbic acid (vitamin C)," *Ann. Intern. Med.* 83:824-826, 1975.
11. Morris, D. W., Hansell, J. R., Ostrow, J. D. et al.: "Reliability of chemical tests for fecal occult blood in hospitalized patients," *Am. J. Dig. Dis.* 21:845-852, 1976.
12. Gilbertsen, V. A.: "Proctosigmoidoscopy and polypectomy in reducing the incidence of rectal cancer," *Cancer* 34:936-939, 1974.

VITAMIN C THERAPY USEFUL IN A GENETIC DISEASE

Large doses of Vitamin C—ascorbic acid—have proved successful in treating a genetic disease which involves faulty production of collagen in the patient's body.

Louis J. Elsas, II, M.D., director of the Emory medical school's Division of Medical Genetics in the Department of Pediatrics, said the Vitamin C therapy has helped prevent further progress of a genetic disease called Ehlers-Danlos Syndrome Type VI.

In this disease, an enzyme necessary for collagen production is impaired. Collagen is a protein which is the principal structural material of muscle tendons, heart valves, cornea of the eye and many other organs. In terms of importance it might be compared with mortar for bricks or nails for lumber in a building.

Dr. Elsas said he decided upon Vitamin C therapy while studying the case of an eight-year-old boy whose symptoms initially resembled scurvy. The patient was bleeding into his skin, for example, and his muscles were weak. His skin lesions didn't heal properly.

On large doses of Vitamin C, the boy's enzyme function increased from about five percent normal to more than 40 percent normal, said Dr. Elsas in a paper given at the National Meeting of the American Federation for Clinical Research in Atlantic City, N.J., May 2, 1975.

"His muscle strength has improved, cornea size has grown, and his scars are normal," said Dr. Elsas. "He had some evidence of potential breathing problems because of muscle weakness, and this has also been helped.

"We're excited about this development, not only because of its clinical implications in helping patients, but because of its research possibilities as well. For example, this is the first enzyme in man involved in collagen production which is now known to be under genetic control."

TOLL-FREE CANCER LINE OPEN

The Southeastern Cancer Research Foundation, a non-profit organization which supports many activities —including clinical research, testing of new drugs and physician education projects—has decided to fund a pilot program called The Georgia Cancer Line, to disseminate information regarding recent advances in the diagnosis and treatment of cancer. A group of consultants throughout the state have agreed to provide information regarding questions which might arise in the management of patients with cancer.

A toll-free phone system has been set up which will allow physicians to call between the hours of 9:00 a.m. and 5:00 p.m. Monday through Friday. The Foundation hopes that if this pilot program is successful, the American Cancer Society will support this project further and allow it to be continued on a permanent basis. The Cancer Line is available to all physicians in the state, requiring only that you call collect, (404) 688-1790.

Management of Congenital Ventricular Septal Defect

WILLIS H. WILLIAMS, M.D., *Atlanta**

Isolated Ventricular Septal Defect (VSD) is the most common congenital heart abnormality, occurring in two of each 1,000 live births and accounting for 20 percent of cardiac defects present at birth. Openings in the ventricular septum persist when the several components of the septum fail to fuse during the first trimester of gestation. A VSD is present in complex defects, including tetralogy of Fallot, atrioventricular canal and other endocardial cushion defects, truncus arteriosus, double outlet right and left ventricle, some forms of transposition of the great vessels and tricuspid atresia, and single ventricle.

The consequences of a VSD—symptoms, need for medical treatment, timing of surgical closure, and the development of increased pulmonary vascular resistance—relate to the magnitude of pulmonary blood flow and pressure. The determinants of pulmonary blood flow include the physical size of the VSD, the relative resistances to egress of blood from each ventricle, and the relationship of the aorta and pulmonary artery to the VSD. Changes in pulmonary vascular resistance modify the volume of blood flowing through the VSD and the persistence of a large VSD may itself produce a progressive and irreversible increase in pulmonary vascular resistance—the Eisenmenger reaction.

For simplicity, we shall discuss three categories of VSD based on anatomical and physiological size—small, moderate, and large. The *small* VSD, less than 0.5 cm in diameter, results in a pulmonary-to-systemic bloodflow ratio (Qp/Qs) of less than 1.5 : 1 and produces no elevation of normal pulmonary arterial pressure. The *moderate-sized* VSD, between 0.5 and 1 cm in diameter, increases the ratio of pulmonary-to-systemic blood flow to between 1.5 : 1 and 2 : 1 and is associated with an increase in pulmonary arterial pressure to a level between 30 and 80 percent of the systemic blood pressure. *Large* defects exceed 1 cm in diameter, increase pulmonary blood flow to more than *twice* that of the systemic circulation, and are associated with an equalization of right and left ventricular pressures.

The symptoms, signs, and presentation of a VSD vary widely. A characteristic systolic murmur and diastolic flow rumble may be detected, increasing in intensity and duration during the first few weeks of life, as the pulmonary resistance falls,

* Associate Professor of Surgery, Emory University School of Medicine and Chief of Surgery, Henrietta Egleston Hospital for Children. Dr. Williams' address is Emory University School of Medicine, Emory University Hospital, 1364 Clifton Rd., Atlanta, Georgia 30322.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

and persists until spontaneous or surgical closure. The murmurs are rarely heard during the first few days of life because of the residual elevation of fetal pulmonary vascular resistance.

The child with a small VSD is likely to be asymptomatic. Mild exercise intolerance, fatigability, dyspnea on exertion, feeding problems, repeated severe respiratory infections, growth retardation, and "failure to thrive" are commonly noted in children with a VSD of moderate size or larger. A large VSD in infancy may be associated with pulmonary edema, bronchospasm, labored respirations and respiratory distress, atelectasis and pneumonitis, left ventricular failure, fluid retention, the "low cardiac output syndrome" (hypotension, oliguria, acidosis, obtundation) and death.

Both electrocardiogram and chest roentgenogram are usually normal when the VSD is small. In moderate defects, left ventricular hypertrophy is present; in large defects *bi*ventricular hypertrophy is usually apparent. The chest X ray of a child with a large defect will reveal cardiomegaly, an enlarged main pulmonary artery segment, an enlarged left atrium, increased pulmonary blood flow, and, in severe cases, pulmonary edema. Sequential chest X rays, electrocardiograms, and cardiac physical examination allow prediction of the course being taken by a dynamic VSD, toward spontaneous closure, the development of right ventricular outflow tract obstruction (tetralogy of Fallot), or irreversible pulmonary vascular obstructive disease (Eisenmenger's reaction).

Although the clinical recognition of a VSD is usually straightforward, the small VSD must be distinguished from pulmonary stenosis, aortic valvular stenosis, and idiopathic hypertrophic subaortic stenosis (IHSS). The moderate-sized VSD must be differentiated from endocardial cushion defects, mitral regurgitation, and a left ventricular-to-right atrial shunt. The large VSD in infancy may pose a problem in a differential diagnosis which includes patent ductus arteriosus and all of the previously mentioned complex defects of which a VSD may be a part. The association of aortic valvular regurgitation or severely increased pulmonary vascular resistance may further complicate the diagnosis.

Management of the child with a VSD demands consideration of the age and size of the patient, severity of symptoms, likelihood of spontaneous closure, and information obtainable only by cardiac catheterization—the size and location of the VSD, the pulmonary arterial pressure, the ratio of pulmonary blood flow to systemic blood flow (Qp/Qs), the magnitude of the pulmonary vascular resistance, and the association of other cardiac defects.

The possibility of spontaneous VSD closure, changes in pulmonary vascular resistance occurring during the first weeks of life, and the increased risk associated with surgery in the neonate influence management of VSD during the first year of life. The small VSD, recognized only by the presence of a typical murmur in the asymptomatic infant, requires only careful observation, no cardiac catheterization, and management of infections which might precipitate subacute bacterial endocarditis. Spontaneous closure of such small defects is likely.

Infants having clinical evidence of a medium-sized or large VSD should first be treated for any symptoms of congestive heart failure by judicious use of digitalis, diuretics, and, when necessary, catechol amines, followed shortly by cardiac catheterization. If the pulmonary arterial pressure is found to be less than 50 percent of the systemic arterial blood pressure, the small infant may be followed safely on clinical grounds. Subsequent catheterization by the age of two years is desirable to confirm spontaneous closure and a fall of the pulmonary arterial pressure to normal. Even if the pulmonary arterial pressure *exceeds* 50 percent of the systemic pressure, the infant may be followed clinically *if* the symptoms of congestive heart failure are controlled. These infants must undergo repeat catheterization six months later, however. This second catheterization may demonstrate a smaller left-to-right shunt and a normal pulmonary arterial pressure, indicating a tendency toward spontaneous closure, in which case continued non-operative follow-up is

appropriate. If, on the other hand, there has been an *increase* or *persistent elevation* of the pulmonary arterial pressure, *surgical closure of the VSD* using cardiopulmonary bypass or circulatory arrest with deep hypothermia is indicated at this time, to prevent further elevation of pulmonary vascular resistance which may lead to inoperability or increased risk even during the first two to five years of life.

If the symptoms of congestive heart failure in the infant with a VSD cannot be controlled medically, two surgical alternatives exist. In the small infant weighing less than 5 kg, or in the critically ill infant with severe pulmonary congestion or infection, palliative pulmonary arterial banding is an effective means of reducing the pulmonary blood flow, controlling congestive failure, and preventing progression of pulmonary vascular obstruction. The band can be removed and the VSD closed when the child is older and stronger. Infants weighing more than 5 kg with refractory congestive heart failure, a large left-to-right shunt, normal or only modestly elevated pulmonary vascular resistance, and reasonable pulmonary status should have the VSD closed, using cardiopulmonary bypass. In some institutions, primary VSD closure is preferred in all infants with significant defects, pulmonary arterial banding being used rarely.

Children over one year of age, with clinical evidence of a medium-sized or larger VSD, should undergo cardiac catheterization. Unless the pulmonary arterial pressure is normal or there is a definite trend toward spontaneous closure based on previous catheterization, surgical closure of the VSD using cardiopulmonary bypass should be advised. If the left-to-right shunt is small or getting smaller and the pulmonary arterial pressure is normal, only prophylactic antibiotic coverage is indicated. Follow-up will often demonstrate spontaneous closure.

The isolated VSD associated with *any* elevation of pulmonary arterial blood pressure and normal or only moderately elevated pulmonary vascular resistance should be surgically closed in the child over one year of age, unless there is *definite* evidence of progressive spontaneous closure. Consideration should also be given to early closure of a VSD associated with infundibular stenosis of the right ventricular output tract, aortic valvular insufficiency, or when the VSD is located in the supracristal position where there appears to be a greater likelihood of the development of aortic valvular regurgitation associated with a prolapsing leaflet.

When the guidelines just described are followed, very few children will progress to inoperable pulmonary hypertension. In the rare situation where pulmonary vascular resistance is found to approach systemic levels (10-13 units), surgical closure of the VSD is contraindicated and may result in operative death or progression of pulmonary hypertension. The prognosis of children with markedly elevated pulmonary vascular resistance is poor, but they will survive longer *without* surgical intervention, although becoming cyanotic as a right-to-left shunt develops and maintains systemic blood flow. When catheterization demonstrates a moderate increase in pulmonary vascular resistance (3-10 units), surgical closure of the VSD should be undertaken even though the risk is greater than expected for the child with normal pulmonary vascular resistance (less than 3 units). In such situations closure of the VSD through the right atrium may be possible, avoiding injury to the right ventricle with subsequent reduction of cardiac output. A fall in resistance after breathing 100 percent oxygen or the administration of a pulmonary vasodilator suggests a greater chance for operative survival, but is not a reliable predictor of post-operative reduction in pulmonary vascular resistance.

The operative mortality for closure of the moderate-sized VSD with normal pulmonary vascular resistance is no greater than 1 percent. With mild-to-moderate elevation of pulmonary vascular resistance, the mortality is about 5 percent. Even the large VSD in small infants can be closed with an operative mortality below 10 percent, deaths occurring primarily in infants with associated cardiac abnormalities or multiple and complex forms of VSD. The mortality associated with surgical VSD closure is basically a function of the severity of pulmonary vascular obstructive disease existing at the time of operation. Although uncommon, complications

associated specifically with VSD closure include complete heart block and incomplete closure or recurrence of the VSD.

In summary, safe management of the infant and child with an isolated VSD now dictates closure of all defects still associated with any elevation of pulmonary arterial pressure by the beginning of the third year of life, unless there is evidence from serial cardiac catheterizations of progressive spontaneous closure of the VSD or, very rarely, inoperable pulmonary vascular obstructive disease. With such management, the parents and child may look forward to a normal and active life.

REFERENCES

1. Rudolph, A. M.: *Congenital Disease of the Heart.* Chicago, Year Book Medical Publishers, Inc., 1974, p. 202-238.
2. Kirklin, J. W., Karp, R. B. and Bargeron, L. M., Jr.: "Surgical treatment of ventricular septal defect," in *Surgery of the Chest,* ed. by Sabiston, D. and Spencer, F. Philadelphia, W. B. Saunders Co., 1976, p. 1032-1048.
3. Collins, G., Calder, L., Rose, V., Kidd, L. and Keith, J.: "Ventricular septal defect: hemodynamic changes in the first five years of life," *Am. Heart J.* 84:695, 1972.

GEORGIA STATE UNIVERSITY OFFERS DEGREE FOR EMERGENCY MEDICAL TECHNICIANS

"Over 50% of the people who have mild heart attacks die before they reach the hospital. The only solution is to get to the patient before he gets to the hospital. The only way to do this is by utilizing the paramedics," said Dr. James Tasse, medical director of Georgia State University's new Emergency Medical Services (EMS) Program and director of emergency services at West Paces Ferry Hospital. Graduates of this program will receive a two-year associate degree and will be certified as an Advanced Emergency Medical Technician or Paramedic.

The EMS program at Georgia State is the only one of its kind so far in the state of Georgia. "Our graduates will have the most advanced paramedic training that the state can presently offer," added Kathy Easterling, program director of the EMS degree and assistant professor of respiratory therapy at GSU.

Crawling through broken car windows to get to a wreck victim, assisting in an emergency childbirth and helping a near-drowning victim breathe, are some of the emergencies that these paramedics will be able to handle.

The students will be trained to handle themselves in almost any kind of emergency. They will become familiar with areas such as cardiology, pharmacology, extrication and communication, defensive driving and EMS management. Part of their course work will involve clinical practice. The students will work in Atlanta area hospitals and gain experience in obstetrics, gynecology, intensive care units, coronary care units, emergency rooms, and will also follow specialists, such as orthopedic surgeons, on their rounds.

"The role and responsibilities of the Emergency Medical Technician (EMT) are to get an ambulance to the hospital as quickly as possible, to stabilize the patient and to work in the environment as an extended arm of the doctor. A very highly trained medical technician is the best way to describe an EMT," stated Tasse. "He is less trained than a doctor, but better trained than a layman," he said.

Most of the present EMT's have received their training from vocational and technical schools around Georgia. "The EMS program at GSU is the only one couched in a university campus and offers a degree," said Easterling. The program will be a model for the state. "We are trying to show the state of Georgia and perhaps the entire Southeast what the role of the paramedic is going to be," mentioned Tasse.

"One thing that the GSU students will have going for them is that most of their teachers will be physicians themselves. The very people that are teaching the paramedics will be working with them later on," Tasse said.

MD VACANCIES IN PROJECT USA

Project USA, the American Medical Association's program to recruit physicians for short-term service (one week to one month), has year-round vacancies at Indian Health Service facilities and National Health Service Corps (NHSC) rural communities.

MDs who participate in this program receive $500 per week plus round-trip air coach fare (or its equivalent) and family housing accommodations.

Malpractice insurance coverage is furnished under the Federal Torts Claims Act for service on Indian reservations; however, the physician must provide his or her own malpractice insurance at a NHSC site. According to the AMA, it is a simple procedure to extend an existing coverage to include short-term service at such a location, and any expense involved in this process will be assumed by Project USA.

Physicians interested in this program should contact John Naughton, AMA, 535 North Dearborn. Chicago, Illinois 60610; (312) 751-6388.

Significant Income Tax Changes in the New Tax Law

DAVID W. SIEGEL *and* PHILIP J. MARZETTI, *Atlanta**

THE TAX REFORM ACT OF 1976 is probably the most significant piece of tax legislation enacted since 1954. Thus, any brief discussion of the Act can deal with only a few of its many and varied provisions. Last month we discussed portions of the Act dealing with estate and gift taxes. This article is intended to highlight some of those income tax sections of the Act which will have the most direct impact on high-income taxpayers.

Minimum Tax and Maximum Tax

One of the more significant changes brought about by the Act is that regarding the minimum tax on tax preference items. The Act raised the minimum tax rate from 10 percent to 15 percent of tax preference items. The minimum tax is now applicable to the excess of tax preference items for the taxable year over the greater of $10,000, or one-half the amount of regular income taxes paid by the taxpayer for the taxable year. The most significant items of tax preference are the 50 percent deductible part of long term capital gains, the accelerated portion of depreciation on real property, and oil and other mineral percentage depletion allowances. The Act adds the following three new items of tax preference: (1) a portion of intangible drilling costs paid or incurred in connection with oil and gas wells (other than costs incurred in drilling a nonproductive well); (2) "excess itemized deductions," which are generally defined as itemized deductions (other than medical and casualty deductions) in excess of 60 percent (but not in excess of 100 percent) of adjusted gross income; and (3) accelerated depreciation on all personal property subject to a lease.

The maximum tax rate on earned income is 50 percent. The Act liberalizes the definition of earned income for purposes of the maximum tax by including in it pensions, annuities and deferred compensation. However, the Act restricts the benefits of the 50 percent maximum tax by reducing the amount of earned income to which it applies on a dollar-for-dollar basis by the amount of a taxpayer's tax preference items for the taxable year.

Tax Shelters

The Tax Reform Act contains numerous provisions aimed at curbing tax shelters. One such provision, the so-called "at risk rule," restricts the deduction of losses incurred in connection with the following activities: (a) the holding, producing or distributing of films; (b) farming; (c) personal property leasing; and (d) exploring for, or exploiting, oil and gas resources. A taxpayer will only be en-

* Prepared at the request of The Medical Association of Georgia. Mr. David W. Siegel is a partner and Mr. Philip J. Marzetti is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

titled to deduct such losses up to the total of his actual capital contributed, the adjusted basis of any property contributed, and the amount of any indebtedness on which he is personally liable. Thus, a taxpayer will no longer be able to take deductions with respect to these activities based on non-recourse indebtedness.

A similar "at risk" provision also applies to partnerships engaged in activities other than those listed above. Unless such a partnership's principal activity is investing in real property (other than mineral property), a partner's basis will no longer include his share of the non-recourse indebtedness of the partnership, except to the extent of any further contributions which he is obligated to make to the partnership. Since a partner may not deduct partnership losses in excess of his basis in the partnership, this provision generally limits the deductibility of partnership losses to the amount of a partner's contribution plus his share of partnership liabilities for which he is personally liable. Thus, in most non-real-estate limited partnerships, the limited partners will not be able to deduct losses in excess of their capital contributions.

The Act also introduces rules governing the allocation of the profits or losses of a partnership. Such profits and losses must be prorated among the partners based on the periods of time during which they were partners and their respective interests in the partnership during such periods. Thus, an investor will no longer be able to purchase an interest in a partnership late in the year and deduct the whole year's loss allocable to that interest. Furthermore, a partner's interest in a partnership will not necessarily be determined by the partnership agreement. The tax allocations of income and losses in such agreement may be disregarded if they lack substantial economic effect.

Interest deductions are also harder to come by. The Act made clear that prepaid interest may not be deducted in the year in which it is paid, but must be capitalized and treated as paid and deducted in the period to which it is allocable. In addition, the deduction for investment interest in any tax year may not exceed $10,000 plus net investment income for such year. Long-term capital gains are no longer treated as investment income for this purpose. Any investment interest not allowed as a deduction can be carried over to subsequent tax years as investment interest.

To supplement the general tax shelter provisions discussed above, the sponsors of the Tax Reform Act also eliminated a number of the tax advantages of those industries generally considered to be tax-shelter industries. For example, in the real estate area, tax and interest incurred during the construction of real property (other than the taxpayer's private home) may no longer be currently deducted. Instead, these expenditures must be capitalized and amortized over a statutorily prescribed period which will eventually reach ten years. The effective date of this provision varies, depending upon the type of real property being constructed. In addition, all accelerated depreciation on residential real property attributable to periods after December 31, 1975, will now be recaptured fully on the disposition of such property.

Upon the disposition of oil and gas property, the Act provides for the recapture as ordinary income of a portion or all of the intangible drilling costs paid or incurred after December 31, 1975, in connection with such property.

The appeal of farming shelters has also been diminished. Besides being subject the "at risk" rule, "farming syndicates" are now required (1) to deduct expenses for feed, seed, fertilizer and other farm supplies only when used or consumed and not when paid; (2) to capitalize costs of poultry; and (3) to capitalize the costs of developing a grove, orchard or vineyard which are incurred prior to the year the grove, orchard or vineyard becomes productive. The term "farming syndicate" includes a partnership or any other enterprise (other than a non-Subchapter S corporation) engaged in the trade or business of farming, if at any time the interests in the partnership have been offered for sale in a registered offering, or if 35 percent of the losses of the venture are allocable to limited partners or limited entrepreneurs (as defined in the Act).

The Tax Reform Act also dealt a severe blow to the patrons of the arts. Individuals and Subchapter S corporations must now capitalize the production costs of movies, books, records and other similar property. These costs are then deductible over the life of the income stream generated from the production activity. This, coupled with the "at risk rule," will severely limit the use of these vehicles as tax shelters.

In summary, at this time the best tax shelter investment is improved real estate. Oil and gas, although somewhat less attractive as a result of the Act, continue to provide substantial tax benefits.

Individual Business and Investment Provisions

The new law revised some of the capital gain and loss provisions. Except for commodity futures contracts, the holding period for long-term capital gain or loss treatment has been increased from six months to nine months for taxable years beginning in 1977, and to twelve months for taxable years beginning after 1977. However, the amount of an individual's ordinary income which may be offset by capital losses has been increased from $1,000 to $2,000 for taxable years beginning in 1977, and to $3,000 for taxable years beginning after 1977.

The rules concerning business deductions for offices in the home and for the rental of vacation homes have been appreciably tightened. A taxpayer will be allowed a deduction for the business use of his home only for expenses attributable to that portion of his home used *exclusively* and *regularly* as his principal place of business or for meeting patients, clients or customers in the normal course of his business. If vacation property is used for both personal and rental purposes, the deduction of expenses (other than taxes and interest, the deductibility of which is not restricted by this provision) incurred in connection with such property shall be limited to the amount of such expenses multiplied by the number of rental days over the total days used. However, if personal use exceeds the greater of 14 days or 10 percent of total use, such deductions may not exceed rental income less deductible taxes and interest allocable to the property. Furthermore, if the residence is rented for less than 15 days, no deductions are allowable and the rental receipts are not treated as income.

Deductions for attending foreign conventions have also been restricted. A taxpayer is limited to two foreign conventions per year, and the Act sets maximum rates for the deduction of travel, meals and lodging expenses. Furthermore, the law requires certain very detailed records to be kept to substantiate these deductions.

Letter to the Editor

Dear Sir:

We read with interest Doctor J. G. McDaniel's story about the nuclear physics professor's practical lesson in solving problems (December issue). The anecdote seemed of such general appeal that we posted it on our company bulletin board in the lunch room. Having noted the chuckles of all who stopped to read it, we now wonder whether we might have permission to reprint the story in "Mediscene," Prudential's newspaper for its three state Medicare-B carriers.

Sincerely

ELIZABETH CURRIE

Personnel Department

Prudential Insurance Company of America

the association
the association
the association

NEW MEMBERS

Afsarzadeh, Maryam Bahreini, Muscogee—Act—ObG
710 Center St., Columbus 31902

Barton, Irene D., MAA—Act—P
300 W. Peachtree St., Apt. 21-N, Atlanta 30308

Bates, Jackson H., Cobb—Act—I
52 Tower Rd., Marietta 30060

Berry, Neil C., MAA—S—Or
Meddac, Ft. McPherson 30302

Cabrera, Lorenzo, Cobb—Act—ObG
Suite 206, 3903 S. Cobb Dr., Smyrna 30080

Daniel, William D., Whitfield-Murray—S—ObG
Box 7692, NRMC Guam, FPO San Francisco 96637

Davis, James W. R., Muscogee—Act—P
Doctors Building, Columbus 31901

Ehbrecht, Martha E., Muscogee—Act—P
2000 16th Ave., Columbus 31901

Gonzalez, Angelo, MAA—Act—SU
2741 Bayard St., East Point 30344

Gorbaty, Lionel, MAA—Act—Path
265 Ivy St., NE, Atlanta 30303

Harris, Herschel B., C. W. Long—R
Athens General Hospital, Athens 30601

Hung, Larry H. Y., Muscogee—Act—Path
Columbus Pathology, Box 4176, Columbus 31904

Kelman, Leslie, MAA—Act—N
25 Prescott St., NE, Atlanta 30308

Kubota, Yutaka, Cherokee-Pickens—Act—ObG
P.O. Box 311, Canton 30114

Moranville, Gary L., Muscogee—Act—P
1953 7th Ave., Columbus 31904

Naffis, Darius, MAA—Act—I
5675 Peachtree-Dunwoody Rd., Atlanta 30342

Purdom, Ernest S., Muscogee—Act—SU
909 Center St., Columbus 31901

Reddy, Ithamukkala J., MAA—Act—Su
33 S.W. Upper Riverdale Rd., Riverdale 30274

Spanjer, Richard F., Whitfield-Murray—Act—Pd
1109 Burleyson Dr., Dalton 30720

Thota, Sindhu H., Glynn—Act—Oph
406 Ocean Blvd., St. Simon's Island 31522

Wallner, Herman W., Muscogee—Act—P
2000 16th St., Columbus 31901

SOCIETIES

Wood W. Lovell, M.D., Medical Director of the Scottish Rite Hospital in Atlanta, spoke to the **Bibb County Medical Society** at its regular meeting this month. He spoke on the "Surgical Treatment of Idiopathic Scoliosis and Scheuermann's Disease."

Rusty Kidd, MAG Director of Legislative Activities, addressed the **Cobb County Medical Society** early this month, informing them of actions taken by the General Assembly.

The **DeKalb County Medical Society** heard Michael H. Mescon at their January meeting. Dr. Mescon, holder of the Chair of Private Enterprise at Georgia State University, talked about the free enterprise system.

Corbett Thigpen, Augusta psychiatrist and author of "The Three Faces of Eve," spoke to the **Screven County Medical Society** last month. The talk was the first of several by distinguished authorities planned by the society as a continuing education project.

PERSONALS

Second District

Bainbridge physician and surgeon **R. S. Carpenter** spoke to a large group as part of the Health Education Series conducted at Memorial Hospital last month. His subject was "Diabetes: complications, body care and diet." Dr. Carpenter is Chief of the medical staff at the hospital.

Third District

The Medical Center in Columbus recently honored **Hugh Bickerstaff** by commissioning a portrait of him to be hung in the Center. The portrait was unveiled in a ceremony last month.

The 73-year-old obstetrician and gynecologist has been practicing medicine since 1929, except for a nine-year period when he headed the Maternal Health Department of the Georgia Department of Public Health.

Dr. Bickerstaff's portrait is the only one of a living physician displayed in the Center.

Fifth District

William A. Reid has been elected president of the Georgia Baptist Medical Center Medical Staff for 1977. Serving with him are **Charles Hancock,** vice president,

and **David Taylor,** secretary. New president-elect is **John G. Leonardy.**

James S. Maughon, Director of Graduate and Continuing Medical Education for Georgia Bapist Medical Center, participated as a group leader in a program on health service areas and regionalization of health care at the 73rd Congress on Medical Education held in Chicago in January.

Sixth District

Newnan surgeon **F. Donald Bass** has been named the recipient of an award for Volunteer Leadership and Service from the March of Dimes. The award read: "Distinguished Volunteer Leadership in Birth Defects Prevention, the fight for quality of life at birth."

A Fellow of the American College of Surgeons, Dr. Bass has worked diligently in the March of Dimes program for over five years.

Ninth District

New Chief of Staff of the Winder-Barrow Hospital is **Hugh O. Hodges.** His Vice Chief-of-Staff is **C. B. Skelton.**

David Field, a family practitioner in Canton, spoke to the Holly Springs PTA last month. His subject was "Good Health: Our Children's Most Important Asset."

DEATHS

Grady Newton Coker, Sr.

Grady Newton Coker, who was President of the Medical Association of Georgia, 1938-39, died February 23 at the age of 82.

Dr. Coker was a graduate of the University of Georgia at Augusta and did his internship in the University Hospital. A native of Canton, he and his father founded Coker's Hospital there in 1923.

Before becoming President of MAG, he was Vice President (1928) and councilor from the Ninth Congressional District. He also served as President of the Cherokee Medical Society, 1925, and the Ninth District Medical Society, 1929.

He was a charter member of the Southern Surgical Congress, a President of the State Board of Medical Examiners and a member of the National Surgeons Congress.

In addition to his involvement in organized medicine, Dr. Coker was an active participant in political activities of his community, county and state. He served as Mayor of Canton for seven terms, was a state senator from the 39th district for three terms, and served one term as state representative from Cherokee County.

Survivors include his wife, Melba Giddens Coker; two daughters, Mary Coker Kelley and Peggy Dean Coker Bass; two sons, Grady N. Coker, Jr., M.D. and Newton Jasper Coker, M.D.

Frank Veverka

Toccoa physician Frank Veverka died instantly when the car he was driving was struck by a train February 14.

Born in Czechoslovakia, Dr. Veverka received most of his medical training in England and in Chicago. He practiced medicine in Chicago for over 20 years before moving to Toccoa, where he was associated with the Toccoa Clinic.

Survivors include a daughter and a son.

MAG SERVICES INCORPORATED

QUALITY AND INEXPENSIVE

PRINTING SERVICES FOR DOCTORS

PRESCRIPTION BLANKS

Standard Size 4¼ x 5½ in Pads of 100

500	1000	2000	4000
5.75	7.95	14.65	26.55

BUSINESS CARDS OR APPOINTMENT CARDS

	1000	2000	4000
White Stock One Side	6.95	12.65	22.95
For Color Stock, Add	1.00	2.00	4.00
For Two Sides	11.85	20.95	39.95

LETTERHEADS

20 LB. WHITE BOND				
SIZE	500	1000	2000	4000
7¼ x 10½ 8½ x 11	11.16	15.70	24.98	42.72
20 LB. RAG CONTENT (25%)				
7¼ x 10½ 8½ x 11	13.90	21.16	35.91	64.75

ENVELOPES

TO MATCH LETTERHEADS

24 LB. WHITE WOVE				
SIZE	500	1000	2000	4000
6¾	12.88	15.96	25.51	47.90
Monarch	13.70	17.59	28.76	54.40
#10	13.77	17.74	29.06	55.00
20 LB. RAG CONTENT				
Monarch	20.23	30.63	54.86	106.60
#10	20.86	33.97	57.43	111.75

WINDOW ENVELOPES

24 LB.

SIZE	500	1000	2000	4000
6¾	13.83	17.84	29.26	55.40
#10	14.85	19.89	33.36	63.60

Composition and type set charges are in addition to quoted prices.

UNIFORM INSURANCE CLAIM FORMS (Approved by AMA)

$18.50/1000 — Single Copies — Pads of 100

SEND ORDERS TO:

MAG SERVICES, INC.

(a service company of the Medical Association of Georgia)

968 PEACHTREE ST., N.E.

ATLANTA, GA. 30309

(404) 873-4136

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

Summary of AMA's NHI Proposals

Four key lawmakers, representing both political parties, have introduced into the new Congress an American Medical Association proposal for national health insurance.

Association President Richard E. Palmer, M.D., urged the 95th Congress and the Carter Administration to consider carefully "this forthright approach to national health insurance. This bill would extend health insurance to every American at a cost the nation could afford. It is a viable solution to the problem of providing quality health and medical care to everyone."

The Comprehensive Health Care Insurance Act of 1977 was introduced into the Senate by Senator Clifford P. Hansen (R-Wyo.) and in the House by Reps. Tim Lee Carter (R-Ky.), John M. Murphy (D-N.Y.), and John J. Duncan (R-Tenn.).

The medical profession's NHI plan would build on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage, with the employer picking up at least 65 percent of the cost. Employees would not be compelled to participate.

The self-employed, as well as the non-employed, could purchase qualified private health insurance through pools if needed, at a cost not more than 125 percent of the cost of group plans. They would have all or part of the premium paid for by the federal government, depending upon their income tax liability.

Small businesses that found the mandated plan an added financial burden would receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would, for the most part, be supplanted under the program.

After a certain level of co-insurance was reached, depending upon income, insurance would cover all remaining expenses as a complete protection against catastrophic costs.

The co-insurance factor would deprive no one of needed care, the sponsors said. The absolute maximum that any individual would have to pay would be $1,500; the absolute maximum for any family would be $2,000 in any given year.

Senator Hansen, a member of the Senate Finance Committee, said:

"The bill we are introducing today would solve the problem of financing for every American. It would guarantee quality medical care to everybody. It would cover the cost of catastrophic illness. It would be fully comprehensive in terms of benefits. It would build on our present system, rather than dismantling it and replacing it from scratch with a new one requiring the creation of a giant bureaucracy. It would allow everyone to choose his or her own physician, dentist and health insurance plan. And it would be a plan we can afford.

"This legislation would cover the poor by paying all of their insurance premiums," Hansen said. "Those better able to afford to pay those premiums would be assisted in a fashion commensurate to their need by lesser degrees of government help. The affluent would even be encouraged to buy health insurance by a tax subsidy of 10 percent of the premium cost.

"As the principal (Senate) sponsor, I am confident that this measure can meet our needs at a cost, in new dollars, that will not be burdensome," the Senator from Wyoming said.

Rep. Carter, ranking minority member of the House Health Subcommittee, said that "—as a member of the House Subcommittee on Health and Environment for twelve years, I have devoted much of my legislative effort to issues concerning our country's health care system. And as a physician, I have made a personal commitment to do what I can to help improve the health care of our people.

"As a co-sponsor of the Comprehensive Health Care Insurance Act of 1977," Carter continued, "I believe this measure offers a workable approach to extending health insurance to every American. In large measure, this proposal retains the expertise and experience of our existing private health care sector in both its administration and financing.

"It is these proven skills and resources of the private sector which I believe we should build upon in developing a national health insurance program, and which should be supplemented only when necessary by government.

"This proposal would provide coverage to the great bulk of the American population through employer-

WHAT ARE YOUR OBSERVATIONS

on pre-hospital care and emergency room care? What have you observed about Emergency Medical Technicians? Do you have ideas for how emergency services can be approved?

The EMS Newsletter would like to publish your 250-500-word articles on this subject. Submit any contributions you may have to:

EMS Newsletter Editor
Emergency Health Section
618 Ponce de Leon Ave.
Atlanta, Ga. 30308 Or Call (404) 894-5170

employee financial arrangements in which not less than 65 percent of the premium would be paid by the employer," Carter said.

"For those who are self-employed or unemployed, health insurance would be provided through an income-tax credit or federal certificate of entitlement system. Thus, this plan would correct one of the major weaknesses of our present system by removing the financial barriers that in the past have denied some Americans access to high quality care."

Rep. Murphy, with Carter a member of the House Interstate and Foreign Commerce Committee, said the proposed legislation would provide "—more comprehensive benefits than any other (proposal) previously considered by Congress; and it would deliver quality health care to everyone—including the poor and the elderly—without bankrupting the nation.

"For those unemployed, or of low or fixed income, and the elderly, premium costs would be paid by the government on an equitable sliding scale," Mr. Murphy said.

"By building the private sector and helping those who need help the most, this approach avoids many of the problems inherent in other proposals before the Congress.

"Further, it would avoid additional burdens on an already beleaguered social security system, the preservation of which must be one of our highest national priorities," according to Mr. Murphy.

Rep. Duncan, a member of the House Ways and Means Committee, questioning how Congress could write a national health insurance plan while at the same time preserving the fiscal integrity of the Treasury, said in prepared remarks:

"The Comprehensive Health Care Insurance Act of 1977 . . . controls costs by limiting federal help to those in need, by determining that level of need from income tax liability. Additional cost controls are found in its co-insurance factor, except for the poor, its provision of preventive care, and its promotion of competition among health insurance carriers."

Comments from Califano

The Carter Administration has announced through its new Secretary of Health, Education and Welfare that a "well-thought through" national health insurance proposal cannot be submitted to the Congress this year.

Joseph Califano, at his first press conference after confirmation as HEW Secretary, predicted that the Administration would first concentrate on health care cost controls and better utilization of existing federal programs.

"Quite frankly," he said, "I'm not sure that we know enough about the larger problems to move faster." In addition, he said, there are other more pressing problems such as reorganization, energy, welfare reform and unemployment that will occupy much of the Administration and Congress' time.

"There's a limit on how much work can be handled intelligently in the time span," Califano said.

He added that most of the policy-making officials at HEW under the Ford Administration are being replaced. This is what the American people expect of a new administration, he added.

Asked about reorganization of the HEW Department and the campaign proposal to make education a cabinet department, Califano predicted there would be no major reorganization proposal for his department that would be ready for submission to Congress this year.

He said he intends to "end politicization" of the National Institutes of Health, especially on the advisory committees, but did not go into any detail.

The major announcement at the conference was a comprehensive study of welfare reform, bringing in all areas of government and the private sector for consultation. Califano said it is clear there is national support for an income security system, but that the public also is "impatient with the inability of our government to remove from the welfare rolls those persons improperly on them." He foresaw a "great national debate" on the issue.

Asked whether groups such as the American Medical Association and the Pharmaceutical Manufacturers Association groups, which have interest in the Medicaid side of welfare, would be consulted, Califano said they will be, as will all other groups involved in welfare programs.

Califano took a couple of swipes at the former HEW Administration, saying he found a "substantial entourage" of 143 officials at the level of the Secretary's Office. He said he plans to cut this substantially and transfer these functions to the responsible agencies, at a savings of more than $500,000.

Federal Fiscal Notes

Medicare and Medicaid spending next fiscal year is predicted to top $35 billion, up more than $5 billion over the current fiscal year. The Ford Administration's final, and somewhat academic, budget proposal to Congress for financing the federal government next fiscal year set overall health, education and welfare spending in fiscal 1978 at $159 billion, an increase of $11 billion. More than $100 billion of this, however, is in Social Security Trust Fund outlays.

There was little new in the budget plans for health compared with last year's budget, except for the steady creep upward (19 percent) of costs for Medicare and Medicaid. Budget requests for most HEW health activities were kept to about this year's level. The Carter Administration is slated to submit its own federal spending plans about mid-February. These are certain to include hefty proposed boosts in some health areas.

HEW spending on health has jumped from $9.7 billion in 1968 to a predicted $42.2 billion. It will rise another $3 billion next year, according to budget charts.

Anti-Fraud Plans

Tightening Medicare-Medicaid fraud provisions is one of the first orders of business before Congress. Legislation has been introduced in House and Senate by key health lawmakers who pledged speedy action.

The bill, sponsored by Sen. Herman Talmadge (D-Ga.) and Reps. Paul Rogers (D-Fla.) and Dan Rostenkowski (D-Ill.), makes provider fraud a felony rather than a misdemeanor; arms Professional Standards Review Organizations (PSROs) with power to review "Medicaid Mills," require certain financial disclosures by non-physician providers, and require PSROs to turn over information to state and federal agencies investigating fraud and abuse as well as health planning agencies.

Rep. Dan Rostenkowski (D-Ill.), Chairman of the

House Ways and Means Subcommittee on Health, said in a House floor speech that "strong efforts must now be made both legislatively and administratively, through a renewed commitment to interdepartmental cooperation, to bring a sense of morality back into our federal health payment programs."

Rep. Paul Rogers (D-Fla.), Chairman of the House Commerce Subcommittee on Health, said the honest, hard-working provider suffers from instances of fraud and abuse, because his reputation is damaged. "We have an obligation to all concerned to improve the administration and management of our medical care programs."

Joint hearings will be held shortly by the two subcommittees on the legislation.

The measure was considered by Congress during the last session, but time ran out before action could be taken.

More sweeping changes in Medicare and Medicaid, including changes in reimbursement methods, are expected to be considered later.

Professional Liability Ruling

The Supreme Court has refused to review a 1975 Florida law designed to substitute mediation for professional liability litigation. Left standing was a decision last May by the Florida Supreme Court, which upheld the state's Medical Malpractice Reform Act. The law makes it mandatory for a complainant to submit to mediation before filing a lawsuit. The three-member mediation panel is composed of a circuit judge, who is the referee, plus a physician and a lawyer. The panel's conclusion as to liability may be admitted as evidence at a later trial.

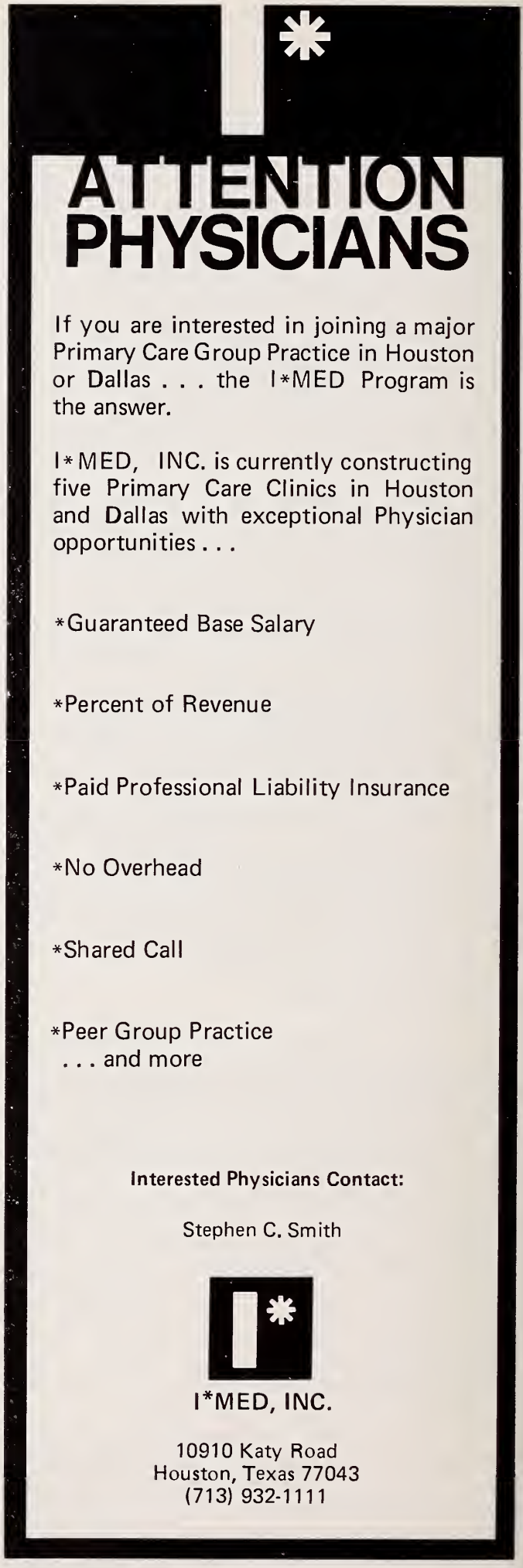
Insurance Coverage

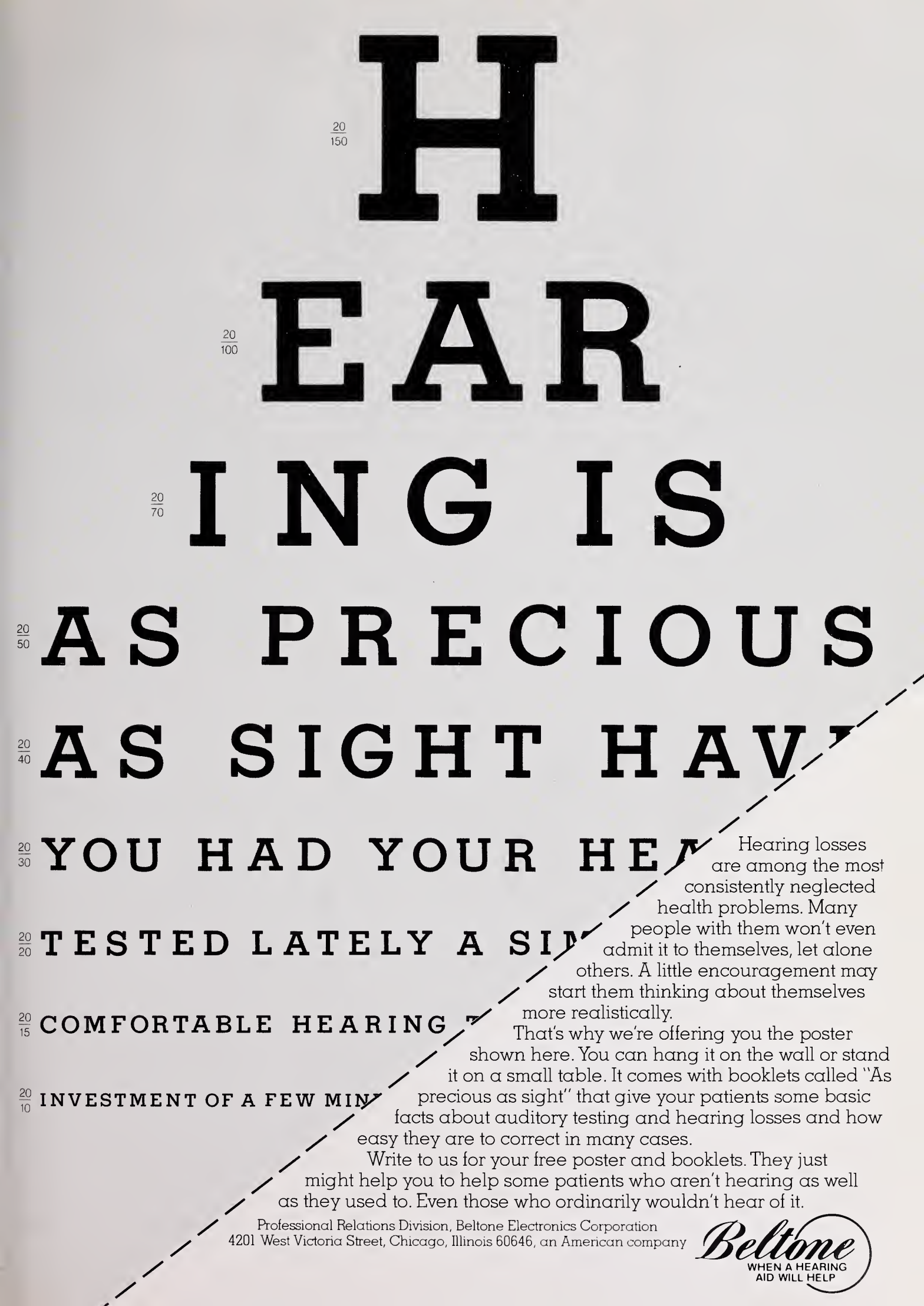
A congressional budget office study declares financing of catastrophic medical costs "does not appear to be a serious national problem for the 103 million persons estimated to be covered by major medical insurance."

According to the report, "major medical insurance has improved so significantly over the last five years that persons holding such coverage are adequately protected against high expenses, especially when such costs are associated with a hospital stay."

The report states that "serious coverage problems" exist for both routine and catastrophic expenses incurred by low-income families. An estimated 40 million persons with projected incomes of less than $10,000 are either uninsured and not eligible for Medicaid, or hold individual (non-group) insurance policies. "Coverage under such insurance is generally very poor." And an estimated 5.6 million families with projected 1978 incomes of less than $10,000 will have out-of-pocket expenses for medical care which exceed 15 percent of their income, the report said.

In addition, a major coverage problem continues in providing protection against the cost of long-term care. "Neither public insurance programs, such as Medicare, nor private insurance plans provide meaningful protection against the cost of long-term care," the report noted. "Mental health services are also frequently excluded from coverage." The study said even people with otherwise good insurance can experience catastrophically high expenses for these services.





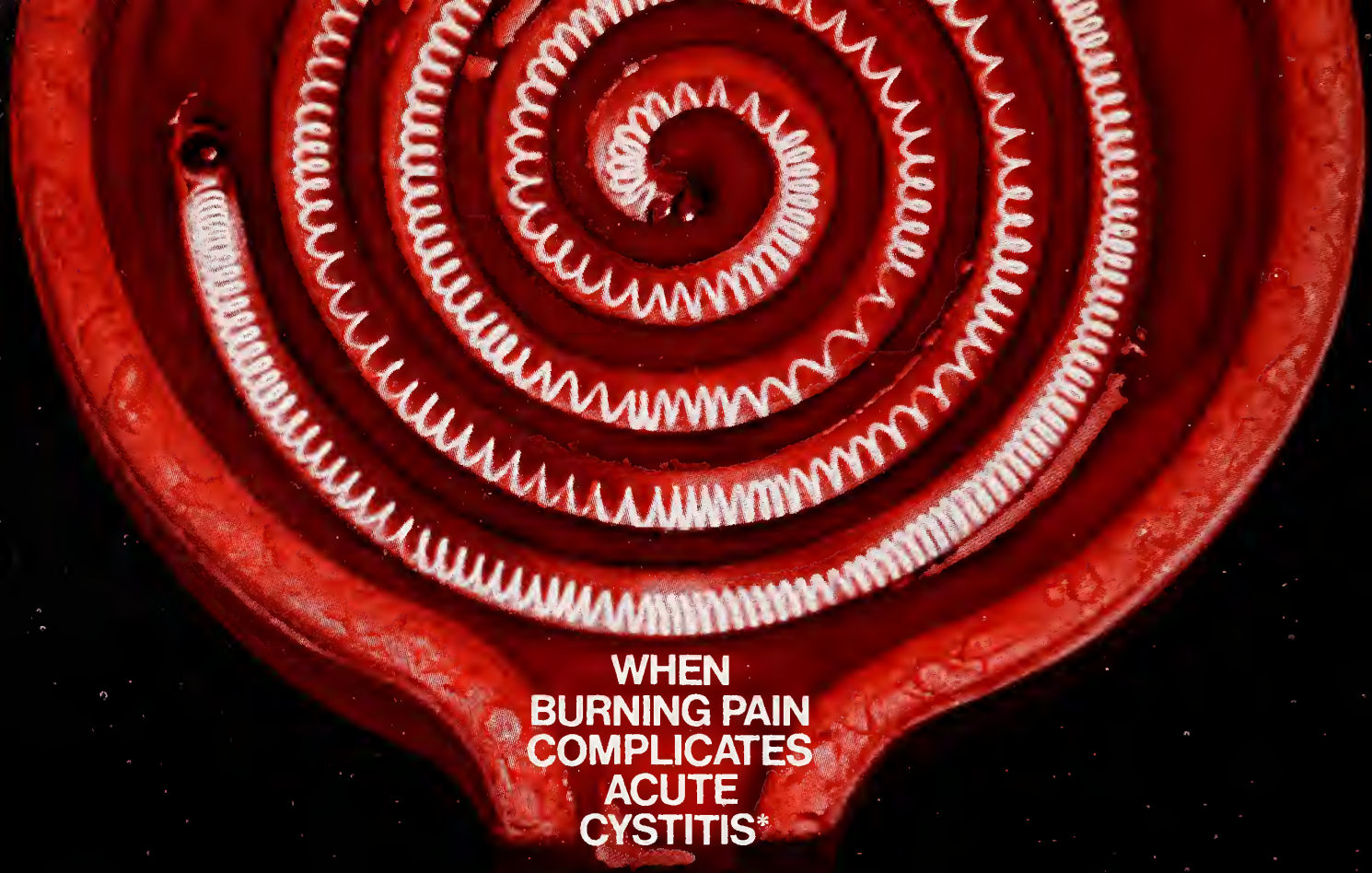
Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP



WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH

AZO GANTANOL®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

*nonobstructed, due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris)* in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

YOU MAKE THE CHOICE.



EMPIRIN® COMPOUND c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

EMPRACET™ c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Opportunities for Continuing Medical Education

HEMATOLOGY/ONCOLOGY FOR THE PEDIATRICIAN

April 4-6, 1977
Atlanta
Category 1 Credit
Contact: Associate Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta, Ga. 30303

NEUROLOGY AND PSYCHIATRY

April 5, 1977
Ft. Oglethorpe
Category 1 Credit
Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Ft. Oglethorpe, Ga. 30742

TECHNIQUES IN ORTHOPEDIC SURGERY

April 7-8, 1977
Atlanta
Category 1 Credit
Contact: Associate Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta, Ga. 30303

COLON CARCINOMA AND CEA GASTROINTESTINAL CARCINOMA, CANCER OF THE LUNG, MELANOMA

April 15, 1977
Savannah
Category 1 Credit
Contact: American Cancer Society, Georgia Division, 2025 Peachtree St., N.W., Atlanta, Ga. 30309

PIEDMONT HOSPITAL POSTGRADUATE SYMPOSIUM

April 16, 1977
Atlanta
Contact: Dept. Postgraduate Education, Piedmont Hospital, Inc., 1968 Peachtree Rd., N.W., Atlanta, Ga. 30309

RECOGNITION AND MANAGEMENT OF CORONARY ATHEROSCLEROTIC HEART DISEASE

April 18-20, 1977
Atlanta
Category 1 Credit
Contact: Associate Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta, Ga. 30303

SYMPOSIUM ON GYNECOLOGIC ONCOLOGY AND EIGHTH ANNUAL WHITACRE LECTURE

April 22-23, 1977
Sarratt Center, Vanderbilt University
Nashville, Tenn.
Contact: Vanderbilt Continuing Education, 305 Medical Arts Building, Nashville, Tenn. 37212

AMERICAN ACADEMY OF NEUROLOGY

April 25-30
Atlanta
Category 1 Credit
Contact: S. A. Nelson, 4015 W. 65th St., Suite 302A, Minneapolis, Minn. 55435

SECOND ANNUAL ST. SIMONS ISLAND SYMPOSIUM ON LUNG DISEASE

April 27-30
St. Simons Island
Category 1 Credit
Contact: Gilbert Grossman, M.D., Dept. of Medicine, Emory University, Atlanta, Ga. 30322

PSYCHO-SOCIAL ASPECTS OF MEDICINE

April 25-27
Atlanta
Category 1 Credit
Contact: Bernard Holland, M.D., Dept. of Psychiatry, Emory University, Atlanta, Ga. 30322

POSTGRADUATE SEMINAR ON GYNECOLOGIC ONCOLOGY AND COLPOSCOPY COURSE

April 28-30, 1977
Atlanta
Category 1 Credit
Contact: American Cancer Society, Georgia Division, 2025 Peachtree St., N.W., Atlanta, Ga. 30309

1977 SOUTHEAST EMERGENCY MEDICINE CONGRESS

May 2-4, 1977
Atlanta
Category 1 Credit
Contact: Medical College of Georgia, Division of Continuing Education, Augusta, Ga. 30902

CARDIOLOGY

May 3, 1977
Ft. Oglethorpe
Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Ft. Oglethorpe, Ga. 30742

INTERNATIONAL CONFERENCE ON PSYCHONEUROENDOCRINOLOGY (Symposia)

May 8-12
Atlanta
Category 1 Credit
Contact: Richard P. Michael, M.D., Dept. of Psychiatry, Emory School of Medicine, Atlanta, Ga. Ph: 404-894-5947

RECOGNITION AND MANAGEMENT OF CONDITIONS THAT PRODUCE CHEST PAIN

May 9-11, 1977
Atlanta
Category 1 Credit
Contact: Associate Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta, Ga. 30303

CURRENT CONCEPTS IN ELECTRODIAGNOSIS

May 12-13
Atlanta
Category 1 Credit
Contact: Emory University, Center for Rehabilitation Medicine, 1441 Clifton Rd., Atlanta, Ga. 30322

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

A unique hospital specializing in treatment of...

ALCOHOLISM
DRUG ADDICTION



In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialities included. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

FAMILY PRACTICE: I will be moving out of state in June. I am looking for someone to buy my Family Oriented Practice of 13 years, located in the heart of DeKalb County, Georgia. If interested, contact Mel T. Moore, M.D., 3646 Market Street, Clarkston, Georgia 30021. 296-7156.

LOCUM TENENS. Internist available for coverage of practice of internal medicine or general practice without surgery for weekends or periods up to one month. Credentials on request. Call (404) 793-8584 after 6 p.m.

FAMILY PHYSICIAN OR GENERAL INTERNIST wanted to join two-man well-established family practice group. Primarily adult practice, no O.B. Pleasant community of 50,000, modern 225 bed hospital, excellent benefits. May inquire through William L. McDaniel, Jr., M.D. or Robert W. Simmons, M.D., 1203 Memorial Drive, Dalton, Georgia 30720, Telephone: 404-278-0138.

OFFICE SPACE FOR LEASE, Clarkston, Ga., eastern metro Atlanta suburb, E. Ponce De Leon Ave., high income DeKalb County residential, up to 6300 sq. ft., available in professional building at $6.50 per ft. negotiable. Rest of building and adjacent building occupied with professionals. Near interstates, hospitals, public transportation, schools, shopping, nursing homes, colleges, sports, recreation, and churches. Beautiful convenient new colonial building, ground floor, no traffic problems, no parking problems, can be finished to suit your needs. Contact William Duke (404) 325-3900.

PHYSICIAN TO HEAD medical sevices for division of vocational rehabilitation, state of Georgia. Requires certification by American Specialty Board. General surgeon or internist preferred. Atlanta capitol hill location, regular hours. Excellent benefits, including three-weeks' paid vacation. Involves limited in-state and out-of-state travel. Begins $33,366. Contact: State Merit System Personnel Administration, 244 Washington St., S.W., Atlanta, Ga. 30334.

FAMILY PRACTICE AND INTERNAL MEDICINE SPECIALISTS needed in several locations—towns or cities. Financial assistance provided for interested physicians. Send curriculum vitae to: Director of Physician Relations, Medenco Hospitals, Inc., Post Office Box 3448, Houston, Texas 77001 or call toll free 800/231-2855—within Texas 800/392-6467.

the
Green Jacket
Restaurant

Steaks • Prime Rib
Seafood
22-Item Salad Bar

240 2nd Street
743-5808

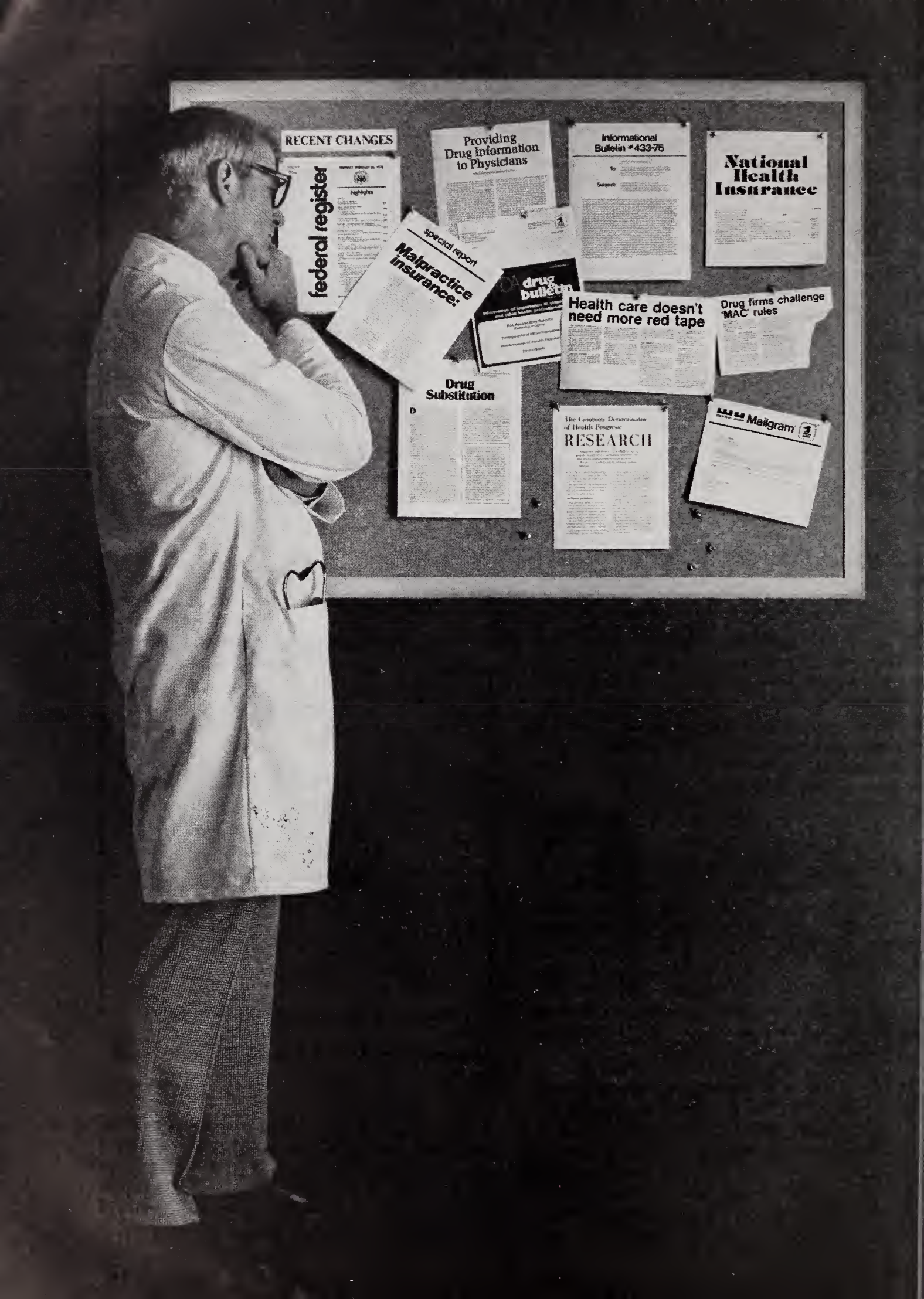
The Green Jacket
(just around the corner from the Hilton)

Eager and Simpson

Since 1919

- ☐ Hospital Fittings of Orthopedic Supports
- ☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972


RECENT CHANGES
federal register
Highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
Special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



METROPOLITAN PSYCHIATRIC

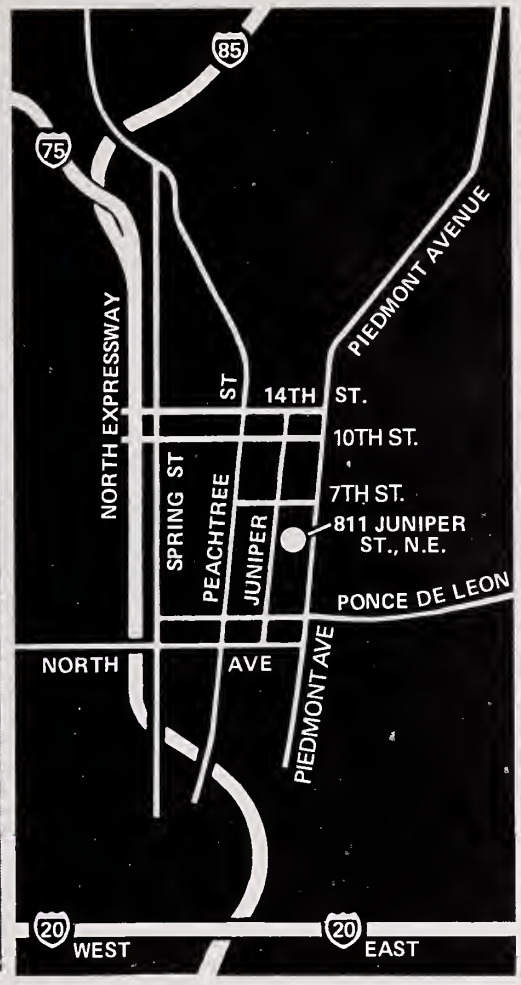
METROPOLITAN PSYCHIATRIC CENTER, cen located in midtown Atlanta, provides comprehens services for adult and adolescent patients in the are psychiatry and alcohol and drugs. Inpatient care, c patient care and partial hospitalization programs ar available at the Center.

In the Psychiatric Program, the attending psychiatr determines from the comprehensive services avail the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

mily Counseling
ychological Testing
cial Work Services
ucational Tutoring
cational Rehabilitation Counseling
ll Radiology Services
tivity Therapy Programs including Occupational
erapy, Recreational Therapy and Art Therapy
Metropolitan Alcohol and Drug Program, directed
ard recovery, offers a structured, comprehensive
roach to the treatment of the physical, psychologi-

cal, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

s Grumet, M.D.
lical Director

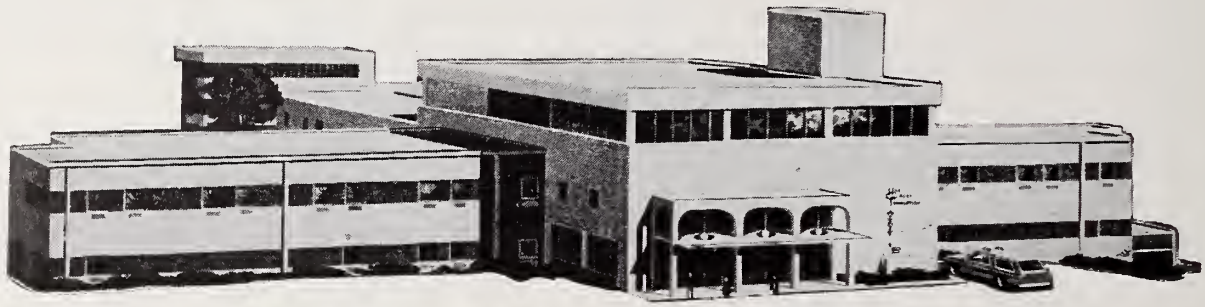
Custis L. Rosser, M.H.A.
Administrator

Douglas Talbott, M.D., F.A.C.P.
ector, Alcohol and Drug Services

opolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

rural primary care ? consider north carolina

North Carolina's Office of Rural Health Services Offers You:

—the chance to discuss practice opportunities in 60 communities from the coast to the mountains

—the opportunity to work with physician extenders if you so desire

—the chance to join a group, partnership, association or to establish a new practice

—the opportunity for you and your spouse to visit a community with the right kind of life-style and medical practice organization

—the opportunity to participate in the North Carolina Area Health Education Centers Program

The Office of Rural Health Services Has Information On 60 Communities For Your Consideration

Please Send Me More Information About North Carolina

Office of Rural Health Services
Department of Human Resources
Box 12200
Raleigh, N. C. 27605

Name _____ (First / Middle / Last)
Address _____ (Street)
_____ (City / State / Zip Code)
Date Available _____
Home Phone _____ Work Phone _____

- ☐ Family Practice
- ☐ Internal Medicine
- ☐ OB/GYN
- ☐ Pediatrics
- ☐ Emergency Room



BREATHING WITH COMFORT.

Choledyl—a highly soluble, true salt of theophylline—rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. *Indications.* Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. *Warning.* Use in pregnancy—animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. *Precautions.* Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. *Adverse Reactions.* Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. *Dosage.* Average adult dosage: Tablets—200 mg, 4 times a day; Elixir—two teaspoonfuls, 4 times a day. *Supplied.* 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose—200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir—bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). *Toxicity.* Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL®
(OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT



When Big Ben looks "a little off"...

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

▪ **Most Widely Prescribed**—Antivert is ıe most widely prescribed agent for the ıanagement of vertigo* associated with dis-ıses affecting the vestibular system such ; Menière's disease, labyrinthitis, and ves-bular neuronitis.

▪ **Relief of Nausea and Vomiting**—ntivert/25 can relieve the nausea and ɔmiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult ɔsage for Antivert/25 is one tablet t.i.d.

RIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200

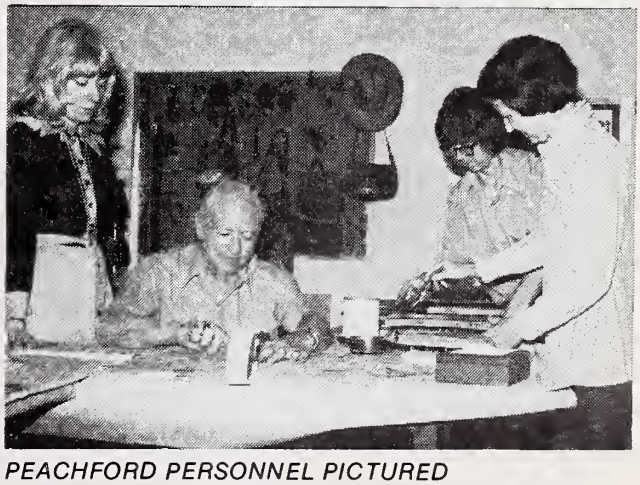




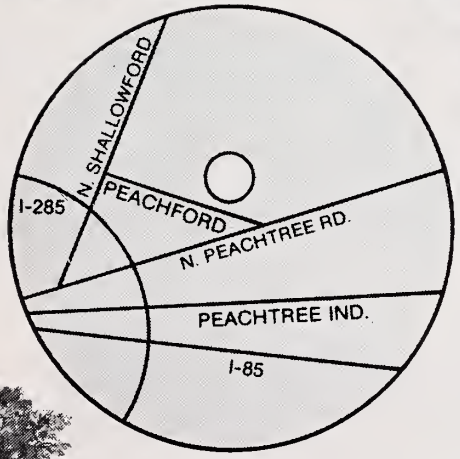








PEACHFORD PERSONNEL PICTURED







Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

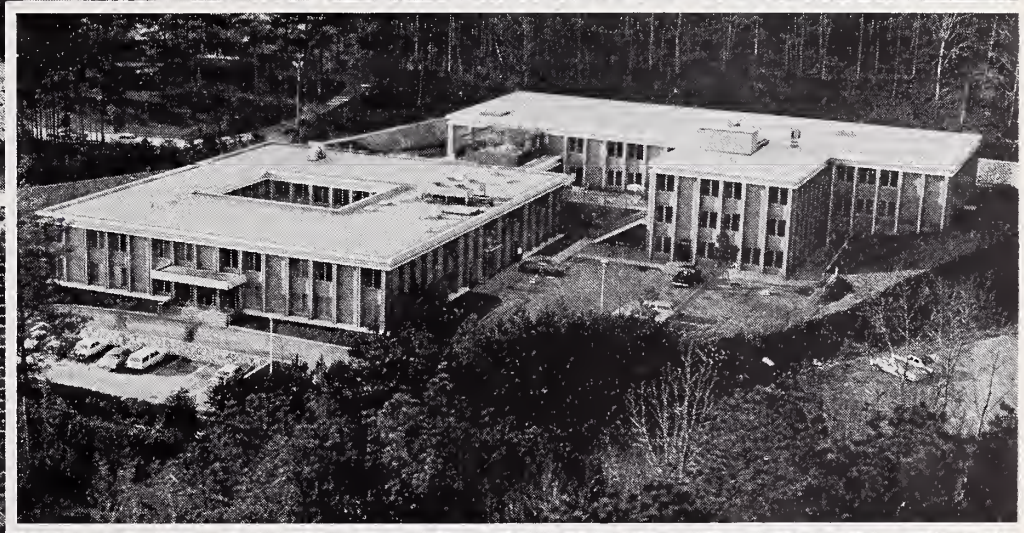
Upjohn

J-5695-6

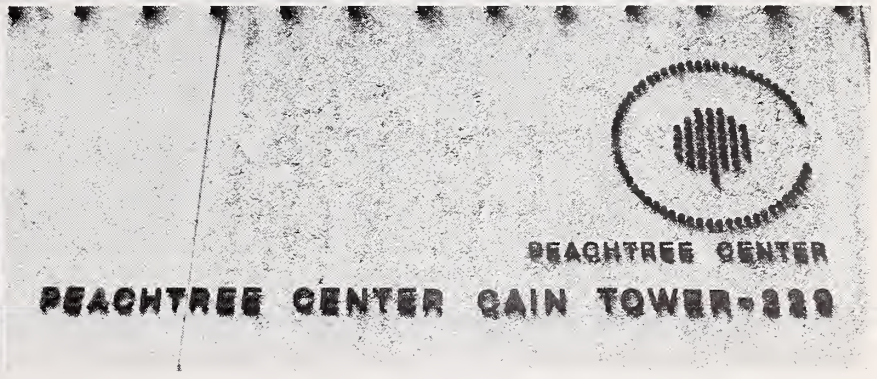
©1977 THE UPJOHN COMPANY











PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.

Parkwood House—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.

- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD
Mental Health Center and Hospitals
1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431
Accredited by the Joint Commission on Accreditation of Hospitals

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

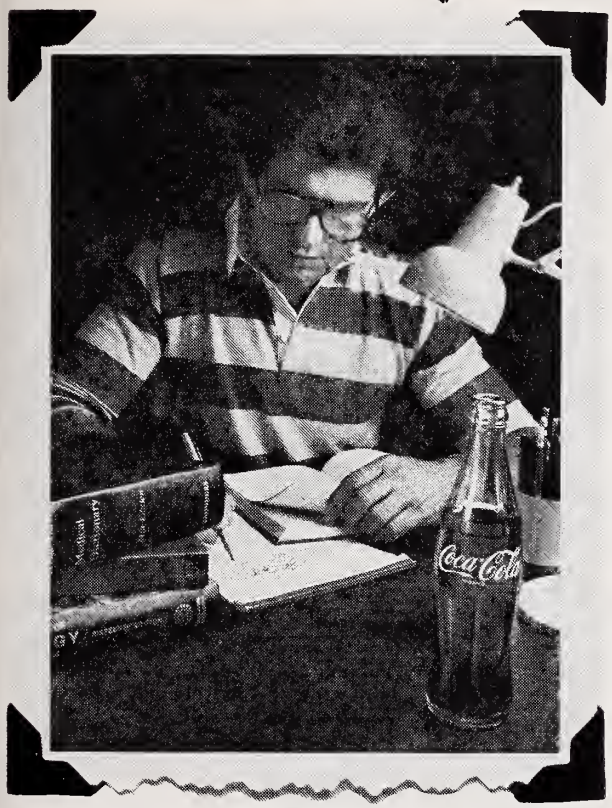
Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

Coke adds life to... those special moments.

Trade-marks



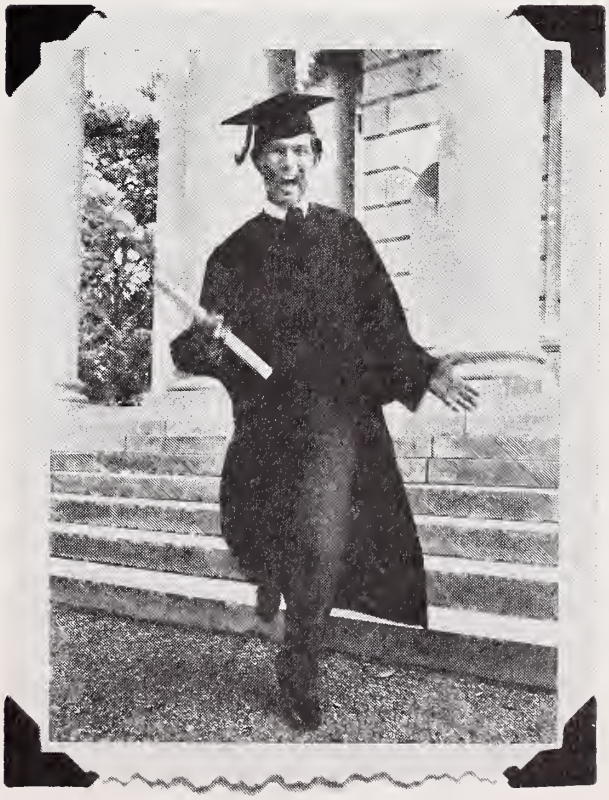
June 2: 2 A.M. Me! Cramming for Inorganic Chemistry finals. Man was I beat!



Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

ola" and "Coke" are registered trade-marks which identify the same product of The Coca-Cola Company.

Index to Advertising

Vol. 66 March 1977 No. 3

Walter Ballard Optical Company 198
Beltone Electronics Corporation 179
Le Bistro Restaurant 132
Brawner Hospital, Inc. 130
Burroughs Wellcome Co. 182
Classified Advertising 185
Coca-Cola Company 199
Dickey-Mangham Company 198
Dorsey Laboratories 137, 138
Eager and Simpson 185
Georgia Society of CPAs 133
Green Jacket Restaurant 185
Hill Crest Hospital 190
I Med, Inc. 178
Eli Lilly and Company 140
Macon Hilton 129
MAG Services 175
Merck Sharp & Dohme 135, 136
Metropolitan Psychiatric Center 188, 189
North Carolina Department of Human Resources 190
Ortega Pharmaceutical Company, Inc. 184
Parke, Davis and Company 134
Peachford Hospital, Inc. 194, 195
Pharmaceutical Manufacturers Association 186, 187
Peachtree and Parkwood Hospitals 197
Potter-Holden & Company 139
Practice Productivity, Inc. 139
Roche Laboratories 128, 180, 201, 202
Roerig 192, 193
Smith, Kline & French 181
Otis Smith—Real Estate 132
The Upjohn Company 196
Valley Psychiatric Hospital 198
Warner Chilcott 191
Weight Watchers of Greater Atlanta 139
Willingway Hospital 184

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

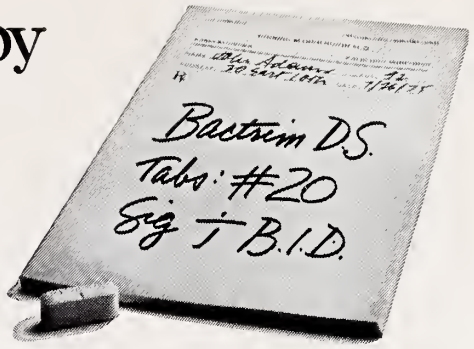
ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™


(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

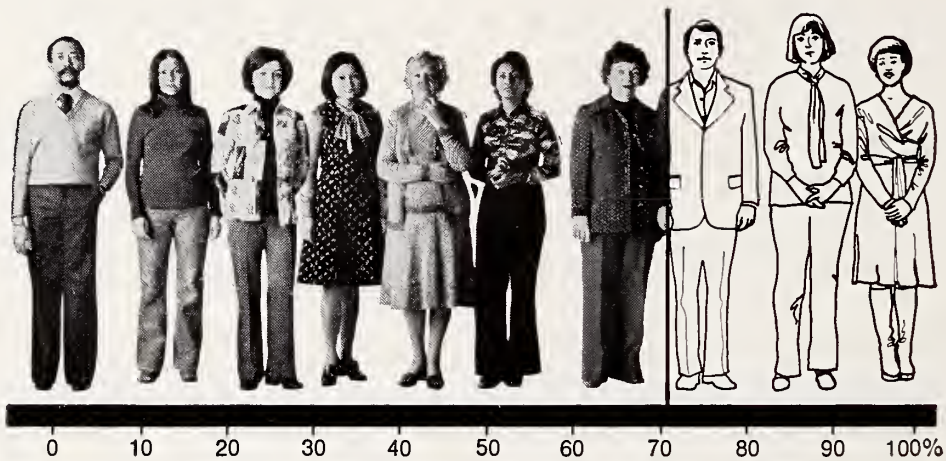
Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

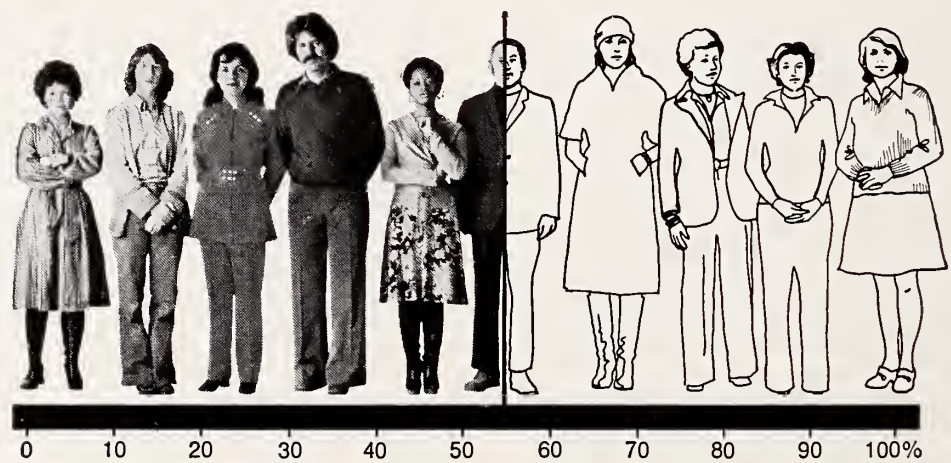
In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Please see summary of product information on preceding page.

ROCHE

JOURNAL
of the medical association of
georgia
APRIL / 1977



MDs make their views known . . . and it pays off.

1977 legislative roundup inside

LIBRARY
SAN FRANCISCO
MAY 5 1977

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



For Help With Your Office Location

What Can We Do?

With years of combined professional experience, we've got the know-how to help you coordinate your move from start to finish. From assistance in finding the most practical location, to help in the negotiation of the best possible lease, to design suggestions for your office space, **we can do it all for you.**

Before You Choose Your Location

Let us provide you with our Professional Space Kit. It's chock-full of all the kinds of information you'll need to help you select your new location -- maps, demographic studies, population data, income information, traffic surveys, and more.

Some of the Medical and Professional Buildings We Manage or Lease:

Buckhead-North Fulton Building
Perimeter View Park
Roswell Professional Center
Forest Park Professional Center
Southeastern Educators Building

workman-brown. inc. realtors

3001 N. Fulton Drive, N.E., Suite 101, Atlanta, Georgia 30305
(404) 261-7222

SPECIALISTS IN PROFESSIONAL SPACE

CALL ON US

BRAWNER HOSPITAL, INC.

Established 1910

3180 ATLANTA STREET, S.E.
SMYRNA, GEORGIA 30080
Telephone 404 436-0081



Located in the metropolitan Atlanta area, this psychiatric hospital is staffed by the members of the Center for Interpersonal Studies, P.A. Emphasis is placed on individual and group psychotherapy on an intensive basis. Each patient is assigned a staff psychiatrist who is responsible for the planning of an individualized treatment program, coordination of the assets of the therapeutic community and a continuing liaison with the patient's family and referring physician.

A comprehensive range of services is provided. There are facilities for evaluation and intensive treatment of patients with emotional problems which can be managed in an open psychiatric facility. An accredited high school is located on the hospital grounds and efforts are made to coordinate work with the local school system.

Member of the American Hospital Association and the National Association of Private Psychiatric Hospitals.

Accredited by the Joint Commission on Accreditation of Hospitals.

Mark A. Gould, M.D.
Medical Director

William H. Benson, M.D.
Psychosomatic Medicine

Ronald C. Bloodworth, M.D.
Psychiatry

Herbert Gorod, M.D.
Psychiatry

Karl S. Mihalovits, M.D.
Clinical Director

Jesse R. Peel, M.D.
Psychiatry

Harry Porter, Jr., M.D.
Psychiatry

Frederick W. Huff, Ph.D.
Psychology

JOURNAL
of the medical association of
georgia

contents

VOLUME 66, NUMBER 4

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF COUNCIL
Fleming L. Jolley
President
Robert E. Perry, Jr., M.D., Brunswick
President-Elect, Chairman of Council
David A. Wells, M.D., Dalton
Immediate Past President
James H. Sullivan, M.D., Columbus
First Vice President
Milton I. Johnson, M.D., Macon
Second Vice President
Earnest C. Atkins, M.D., Atlanta
Secretary
Carson B. Burgstiner, M.D., Savannah
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Ronald F. Galloway, M.D., Augusta
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

225 Cystoid Macular Edema after Intracapsular Cataract Extraction and Phacoemulsification
William S. Hagler, M.D.
Thomas P. Manchester, M.D.
220 Percutaneous Biopsy of the Liver Using a New Disposable Needle
Mario J. R. Ravry, M.D.

SPECIAL ARTICLES

217 1977 Legislative Roundup
James A. Kaufmann, M.D.
Rusty Kidd
222 Decision Making in Health Care
Edward J. Fechtel Jr.

EDITORIAL

228 Ophthalmologists and MAG Join Forces
Roger R. Rowell, M.D.

FEATURES

230 President's Letter/Don't Forget Our Purpose
Robert E. Perry Jr., M.D.
231 I've Told This Before/Flag Man at the Nursing Home
J. G. McDaniel, M.D.
233 Cancer Page/Report on Liver Tumors and Oral Contraceptives
Gerald P. Murphy, M.D.
235 Heart Page/Update on Metropolitan Emergency Medical Services
J. Norman Berry, M.D.
237 Legal Page/Federal Health Maintenance Organization Amendments of 1976
Scott Killingsworth

THE ASSOCIATION

242 New Members
242 Societies
243 Personals
243 Deaths

NEWS

224 Ask Medicare
227 Education for Residents
236 Advanced Life Support Instructor Course
243 Certification Exam for Physician's Assistants
245 The Month in Washington
247 Where Your Tax Money Goes
253 Medical Meeting Calendar

THE COVER

When people take the time to make their views known to lawmakers, it can make a difference. MDs from all over the state proved this point at this year's General Assembly. For a rundown on the results, see page 217. Cover art by Bob Hamill, Atlanta.

BE THE DOCTOR YOU WANT TO BE.

Today, Navy Medicine gives you the opportunity to be the doctor you want to be. We offer a challenging practice with a minimum of administrative overhead. Plus excellent facilities and support personnel.

In addition, a Navy practice gives you time to spend with your family. Associate with other highly motivated physicians. Further your schooling. Even enjoy 30 days' paid vacation every year.

All this, plus a starting salary of $30,000 or more a year, depending on your experience.

For more information, contact:

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

SHERWOOD'S
PROFESSIONAL PRACTICE SALES

A unique business brokerage service specializing in the confidential presentation of professional practices for sale.

Sherwood's Commercial Brokers

North Center, Suite 201
4319 Covington Highway
Decatur, Georgia 30035
404/288-1330

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

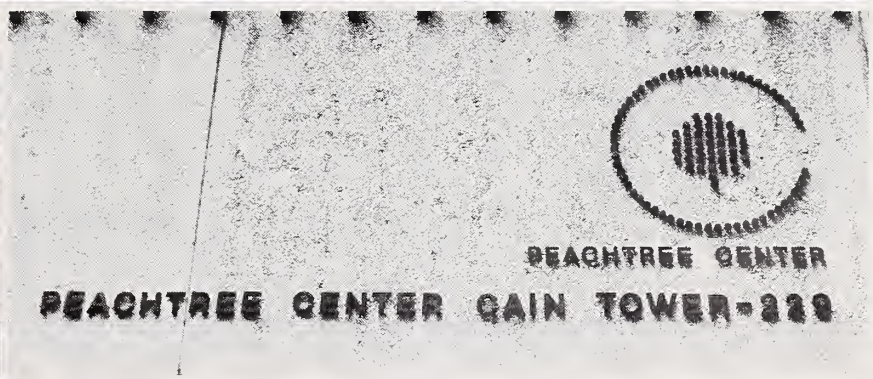
Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344











PEACHTREE & PARKWOOD SATELLITE SERVICES

n line with its philosophy of providing compre-ensive mental health care for all of Metro-olitan Atlanta, Peachtree and Parkwood has stablished four satellite services: one down-own at Peachtree Center, two at Duluth in winnett County, and one on Briarcliff Road t University Drive. The satellites are:

Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.

Parkwood House—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.

- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

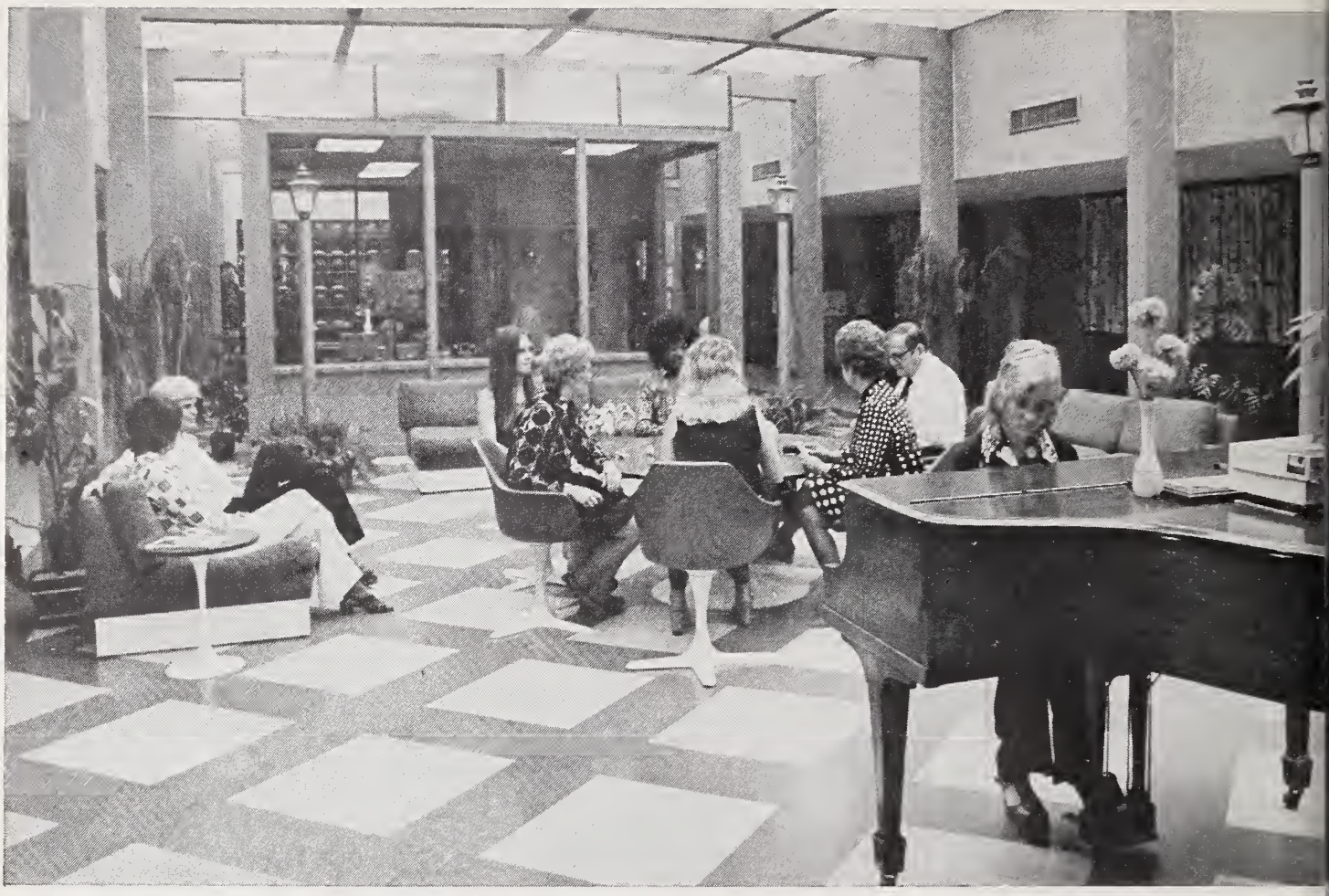
For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals



METROPOLITAN PSYCHIATRIC

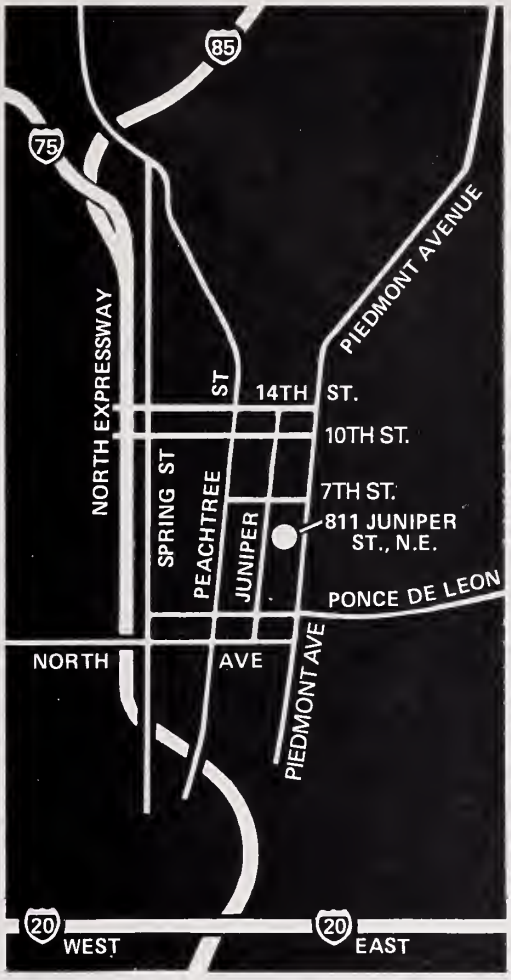
METROPOLITAN PSYCHIATRIC CENTER, centr
located in midtown Atlanta, provides comprehensiv
services for adult and adolescent patients in the area
psychiatry and alcohol and drugs. Inpatient care, ou
patient care and partial hospitalization programs are
available at the Center.

In the Psychiatric Program, the attending psychiatris
determines from the comprehensive services availa
the most appropriate modality(s) of treatment, but
always within the theme of individualized care.

The following services are available through the
psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

amily Counseling
sychological Testing
ocial Work Services
ducational Tutoring
ocational Rehabilitation Counseling
ull Radiology Services
ctivity Therapy Programs including Occupational herapy, Recreational Therapy and Art Therapy

e Metropolitan Alcohol and Drug Program, directed vard recovery, offers a structured, comprehensive proach to the treatment of the physical, psychological, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

s Grumet, M.D.
dical Director

Custis L. Rosser, M.H.A.
Administrator

Douglas Talbott, M.D., F.A.C.P.
ector, Alcohol and Drug Services



ropolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD-JA-1699-2-P (8-76)

Parke, Davis & Company
Detroit, Michigan 48232

When it's pinworms, treat the family



Povan® (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS



BREATHING WITH COMFORT.

Choledyl – a highly soluble, true salt of theophylline – rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. *Indications.* Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. *Warning.* Use in pregnancy – animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. *Precautions.* Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. *Adverse Reactions.* Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. *Dosage.* Average adult dosage: Tablets – 200 mg, 4 times a day; Elixir – two teaspoonfuls, 4 times a day. *Supplied.* 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose – 200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir – bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). *Toxicity.* Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

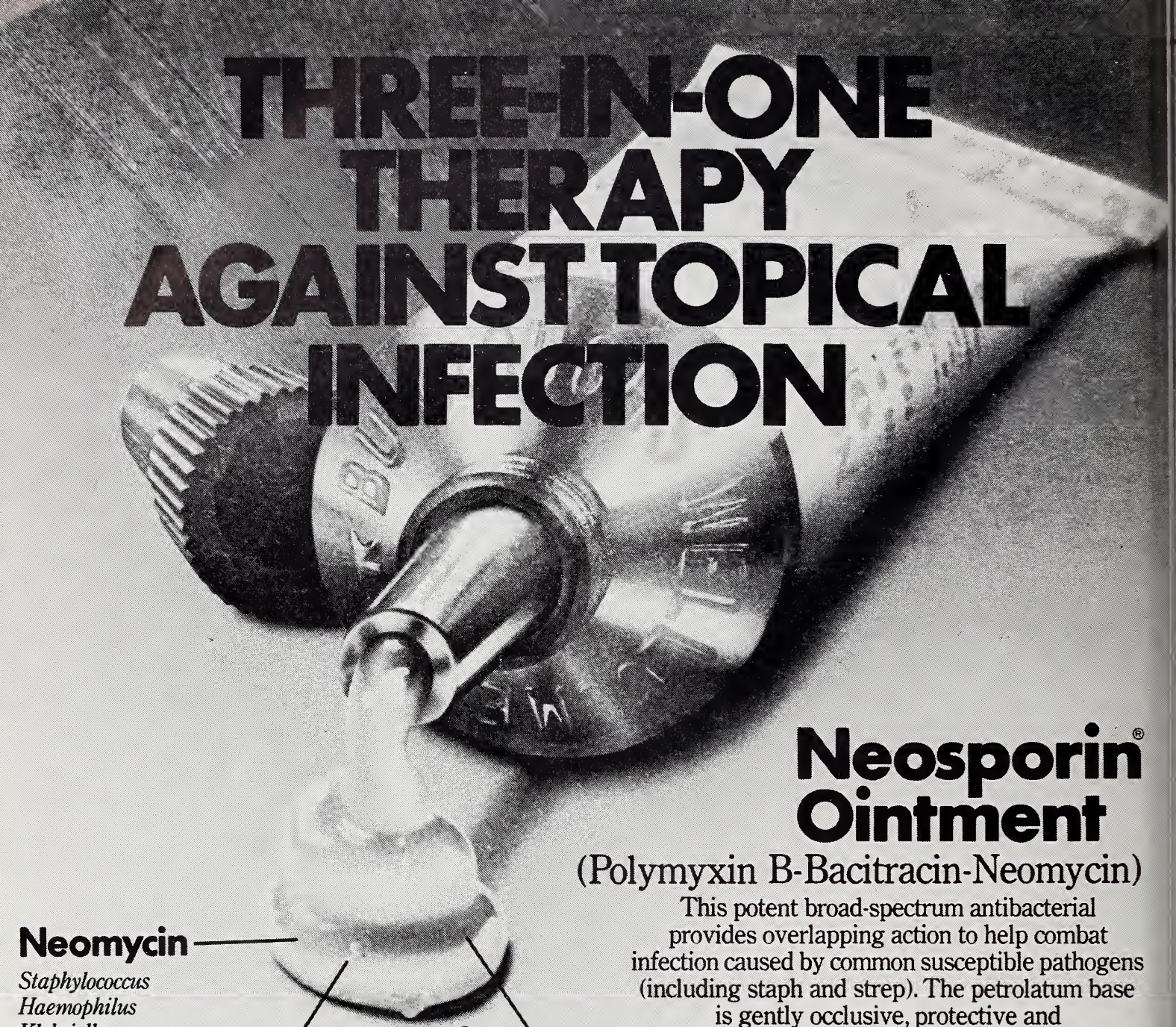
CH-GP-51-4/C

WARNER/CHILCOTT
Division Warner-Lambert Company
Morris Plains N.J. 07950

CHOLEDYL®
(OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

how do others avoid tax headaches? your CPA knows.



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

GEORGIA CPA SOCIETY

GEORGIA SOCIETY OF
CERTIFIED PUBLIC ACCOUNTANTS

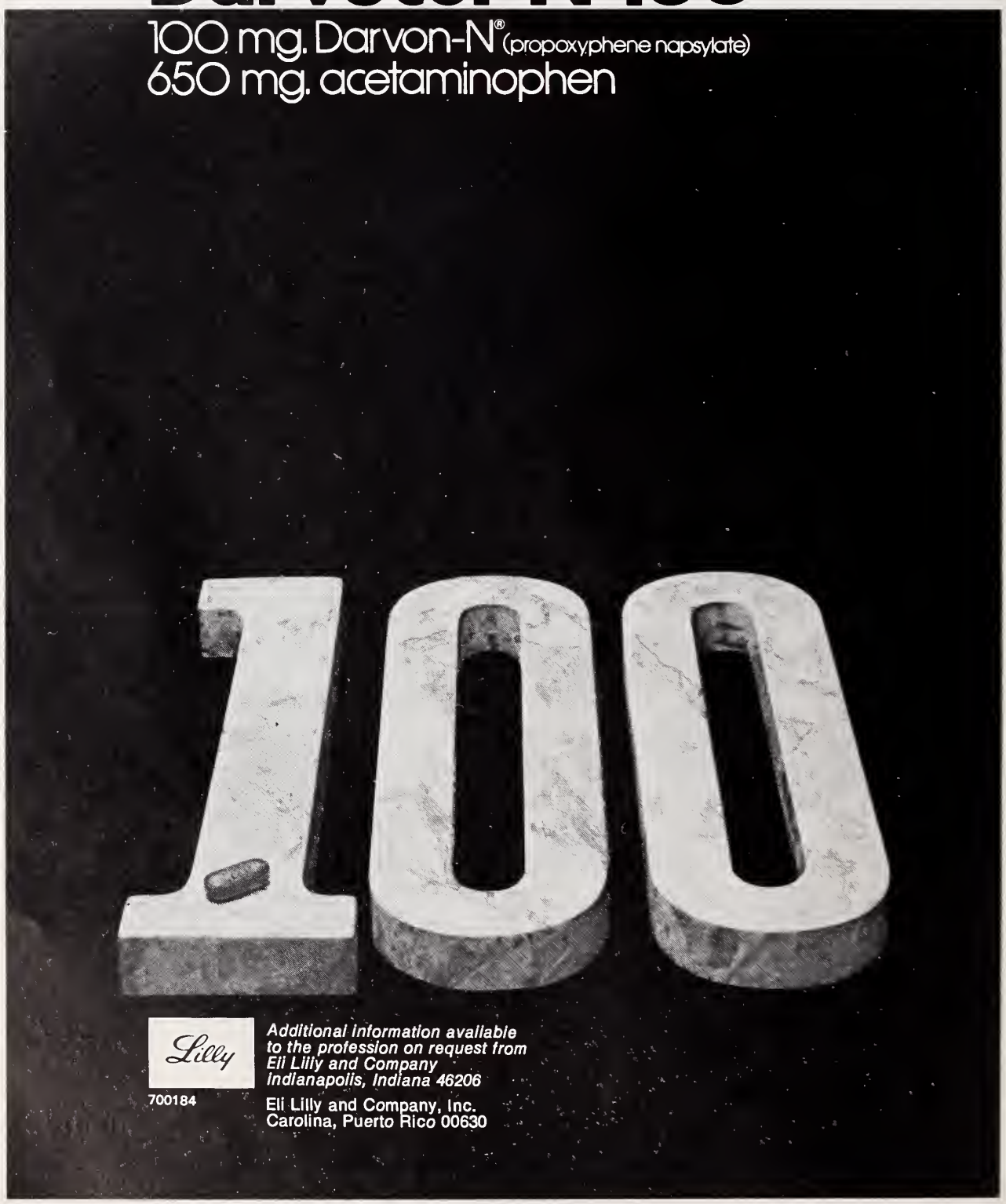
4105A

contains no aspirin

tablets

Darvocet-N® 100

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

700184

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

JOURNAL
of the medical association of
georgia

1977 Legislative Roundup

JAMES A. KAUFMANN, M.D. *and* RUSTY KIDD, *Atlanta**

The Georgia General Assembly considered 67 bills which were of direct interest to MAG members. A report on some of the most significant ones.

At 12 o'clock AM, Thursday, March 10, 1977, the Georgia General Assembly adjourned. During this session, there were 2,235 bills and resolutions introduced. Of this number, your Association took an active part in testifying and providing information on 67 of these bills. I am proud to say that because of the involvement of our membership, no bill was passed which MAG vitally opposed and only one bill has been delayed which MAG strongly favored. Even this one bill passed the Senate, is still pending before the House and will be acted on early in the 1978 Session.

This year could be deemed a milestone for the membership of the Medical Association of Georgia. By this, I mean for the first time in my many years of being involved with legislation on behalf of the Medical Association, when we had a hearing on a very controversial bill, I looked in the gallery surrounding the Senate Chamber where this bill was being discussed and saw approximately 115 supporters for the Medical Association. Of this 115, it would be safe to say 80 were active MAG members. In the past we have tried on numerous occasions to solicit MAG members to come to the Capitol and let their wishes be known. When these 80 physicians took time from their practice to be in the Capitol on the same day and talk to their legislators about the same specific issue, it had an overwhelming effect on the entire Georgia General Assembly, one which will not be forgotten, and one which I and your committee hope will be repeated numerous times in the years to come.

DOCTOR-OF-THE-DAY PROGRAM

MAG sponsors, during each legislative session, a Medical Aid Station which is staffed by volunteer physicians throughout the state of Georgia and is known in our ranks as the "Doctor-of-the-Day Program." This program serves two purposes. One, physicians are available to treat the every day ills of our legislators, and secondly, this is a vital public relations link between physicians in Georgia and the Georgia Legislature. These volunteer physicians throughout the State gave one day of their time to come to Atlanta to serve the General Assembly this past year and they are to be commended for this effort. At the same time, I think each one of these physicians will state it was an educational experience for them as well.

PHYSICIAN LEGISLATORS

We are fortunate to have two Georgia physicians-MAG members who are currently serving in the Georgia House of Representatives. Dr. Wilbur Baugh, a radiologist from Milledgeville, is now in his second term as a member of the House of Representatives. Wilbur has served the past three years on the House Health and Ecology Committee. Wilbur is currently serving on the Appropriations, Health and Ecology and State Institutions and Property Committees.

Our other physician in the Georgia Legislature is Dr. J. Roy Rowland from Dublin. Dr. Rowland is currently serving on the House Health and Ecology Committee, House Judiciary Committee and House

* Dr. Kaufmann is Chairman of MAG's State Legislative Committee. His address is 950 West Peachtree St., NW, Atlanta, Ga. 30309. Mr. Kidd is MAG's Director of Legislative Activities.

State of the Republic Committee.

Both Dr. Baugh and Dr. Rowland have undertaken the supreme sacrifice of leaving their practices in their towns to serve the state of Georgia as members of the House of Representatives. Every physician in Georgia owes Wilbur and Roy a great deal of gratitude and appreciation for their time and efforts and involvement in serving in the General Assembly. There is no way to explain how having two

This year could be deemed a milestone for the membership of MAG.

physicians in the Legislature is of assistance to MAG and the State of Georgia regarding Health Legislation. If every MAG member feels as I do, Dr. Rowland and Dr. Baugh should receive 5,250 letters within the next two weeks thanking them for their service and their hard work. Their addresses are: Wilbur E. Baugh, M.D., Post Office Box 926, Milledgeville, Georgia 31061, and J. Roy Rowland, M.D., 103 Woodbridge Road, Dublin, Georgia 31021.

LEGISLATION OF INTEREST TO MAG

The following is a review of 17 of the 67 bills which were of concern to MAG this year:

H.B. 46 Hospitals-Emergency Room Physicians

Failed in the House Committee; MAG strongly opposed. This bill would have required every hospital to designate a primary and a secondary call practitioner for emergency room care. The primary call practitioner would have twenty minutes to respond to the emergency call and the secondary practitioner would have forty-five minutes. Both would be liable for any medical malpractice or negligence which might have occurred if they had not arrived after their respective times.

H.B. 57 Generic Drug Substitution

Passed House and Senate; MAG did not oppose. Effective January 1, 1978, this bill requires that every prescription form be changed to include two lines on which the physician may sign. The top line indicates "generic substitution permitted" and the second line indicates "dispense only as written."

H.B. 212 Board of Medical Examiners Reports by Hospitals

Passed House and Senate; MAG supported. This bill requires all hospitals to report to the Board of Medical Examiners those physicians whose hospital privileges have been revoked. This does not apply to suspension of privileges due to record keeping, and only applies to those privileges suspended after all appeals have been sought.

H.B. 234 Health Maintenance Organizations

Passed the House Insurance Committee, defeated by the House, reconsidered and tabled. This bill would permit Georgia to conform with the Federal Laws and enable HMOs to obtain initial start up money from the Federal Government. MAG's basic philosophy is in opposition to Health Maintenance Organizations.

H.B. 244 Maternity Insurance

Passed both House and Senate. This would require insurance companies to write a maternity insurance package to include in this package complications of pregnancy. MAG supported.

H.B. 251 Board of Medical Examiners— License to Practice Medicine

Passed House and Senate, now law. MAG vigorously supported. This new law states a judge cannot suspend the Medical Board's revocation of a doctor's license without first making a positive finding that by allowing the doctor to continue practicing, it will not endanger the public's health.

H.B. 252 Board of Medical Examiners— Immunity From Liability

Passed House and Senate, now law. MAG vigorously supported. This states those persons who provide information to the Medical Board are given immunity from being sued by the doctor about whom they give information, as long as their testimony and/or information to the Board is given in good faith.

H.B. 502 Medicaid Reorganization

Passed House and Senate, now law. This officially, by Georgia Statute, takes the Department of Medical Assistance out from under Department of Human Resources.

H.B. 769 Cancer Advisory Committee

Passed House and Senate; MAG supported. This law creates a Cancer Advisory Committee to the Department of Human Resources and the State to establish programs of prevention, control, etc., and to advise the State as to the dangers of cancer and as to the needs of monies by State appropriation in this area. One main purpose of H.B. 769 is to prevent in the future monies which should go to the cancer program being sidetracked to other departments under DHR.

S.B. 18 Adoption Law

Passed House and Senate, already signed by the Governor; MAG supported. This new law completely rewrites Georgia's old and antiquated adop-

tion laws. MAG committees and others worked on this bill for the past three years to adopt a version suitable for the Georgia Legislature.

S.B. 20 Optomery

Pending before Senate Human Resources Committee; MAG vigorously opposes. Under this proposal optometrists would be able to use diagnostic drugs without having received the adequate education and training as to the side effects and uses of said drugs.

S.B. 85 Malpractice Testimony—Local Level

Passed the Senate, pending before the House Judiciary Committee; MAG supports. The Senate version of this bill states testimony pertinent to a professional liability case can only be given by persons who are familiar with that mode of practice within the State of Georgia. The results of the passage of S.B. 85 would seriously curtail those witnesses-for-hire who travel throughout the country giving medical malpractice testimony.

S.B. 99 Emergency Medical Technician

Passed House and Senate; MAG supported. Under this proposal, all EMTs will be certified and supervised by the Composite State Board of Medical Examiners. Additional funds have been provided to the Board to certify EMTs.

S.B. 297 Driver's License Advisory Board

Passed House and Senate; MAG supported. Before the passage of S.B. 297, wording of the law stated that physicians "shall" report to the Department of Public Safety those persons, who in the physician's estimation, could not drive an automobile safely. MAG requested the word "shall" be changed to "may," which was the effect of S.B. 297.

S.B. 369 Hypnotism

Currently pending before the Senate Judiciary Committee; MAG supported. This bill was introduced late in the session and the hearing on the hypnotism issue will come up during the summer months.

OTHER ISSUES

As you can see, the above mentioned bills were only a few, but there were many of which MAG participated. If you have any questions regarding any of the mentioned bills or any legislation, feel free to contact MAG Headquarters.

Your response to the MAG Legislative Bulletin that goes out weekly during the session has been overwhelming. I cannot urge you enough to communicate your wishes and desires to MAG, AMA, our Congressional Delegation on National issues, your State Representative and State Senator, Governor and Lt. Governor regarding your position on legislation. It is through the contacts you and MAG make regarding these issues that MAG obtains the success which we have seen in past years in the Georgia Legislature.

Keep up the good work, and thank you for your help!

Physicians who served as Doctor-of-the-Day this year

James A. Kaufmann Atlanta	Henry R. Richbourg Nashville
Kevin Lane Albany	Beverly Sanders Macon
Fleming Jolley Atlanta	Stewart Brown Royston
Wallace Lucus Cochran	Rick Dubois Atlanta
Roland Summers Savannah	Charles Releford Griffin
M. C. Adair Rome	J. W. Chambers LaGrange
J. R. B. Hutchinson Atlanta	Charles Gillespie Albany
Wells Riley Jonesboro	Jimmy Baugh Milledgeville
Larry Freeman Atlanta	Charles Durden Fitzgerald
Steven May Kennesaw	Bill Morton Chamblee
James Marlow Dalton	Michael Oconnell Waycross
George Green Sparta	Jack Menendez Macon
Duane Blair Decatur	James Traylor Athens
Don Schmidt Cedartown	Larry Freeman Decatur
Ben Looper Canton	Curtis Hames Claxton
Barry Darugar Eatonton	Louie Griffin Augusta
Henry Stegeman Athens	John Gamwell Atlanta
Gerald Filardi Decatur	Lamar Cousins Marietta
Jack Johnston Dahlonega	Stewart R. Roberts Atlanta
Bill Stom Decatur	Hugh O. Hodges Winder
E. Anthony Musarra Marietta	James Dismuke Adel

The Tru-Cut needle is a modification of the Vim-Silverman needle which incorporates all of its essential features into a single-piece instrument.

Percutaneous Biopsy of the Liver Using a New Disposable Needle

MARIO J. R. RAVRY, M.D., F.A.C.G., *Atlanta**

PERCUTANEOUS NEEDLE biopsy of the liver plays a most important role in the evaluation of liver disease throughout the world. It enables the physician to obtain in a simple manner a sample of liver parenchyma for histologic study, biochemical investigations, and/or immunologic studies.[1] In the United States, needle biopsy of the liver is most frequently performed with either the Menghini aspiration needle or the Vim-Silverman needle.[1] Recently, a new type of biopsy needle, the Tru-Cut® (Figure), which is disposable and incorporates all the features of the Vim-Silverman needle into a single-piece instrument, was introduced.[4] The results of my preliminary experience employing the Tru-Cut for percutaneous needle biopsy of the liver are presented in this report.

Material and Methods

Thirty consecutive percutaneous liver biopsies were performed in 29 patients using the Tru-Cut® biopsy needle (Travenol Laboratories, Inc., Deerfield, Illinois). All patients underwent liver biopsy for confirmation and definitive histologic diagnosis of suspected liver disease. All patients were hospitalized. All had hemoglobin levels greater than 10 grams%, normal platelet counts and prothrombin time, and were able to cooperate fully with the operator during the procedure. Biopsies were performed in the usual manner, following the Vim-Silverman technique[1] modified for the use of the Tru-Cut®.[4] Following incision of the skin with a No. 11 scalpel blade, the needle obturator is fully retracted by pulling on the obturator handle so that the cannula covers the specimen notch. The needle is inserted through the incision and advanced through the chest wall into the liver substance. The obturator is advanced into the liver substance so that the specimen notch is within the liver parenchyma.

Without moving the obturator, the cannula is advanced (by pushing the cannula handle) over the inner needle to cut the piece of tissue that has prolapsed into the specimen notch and lock it into place. The entire instrument is removed from the body, with the cannula still covering the obturator and specimen notch. All patients were kept at bedrest for 24 hours after biopsy. Vital signs were monitored before and at specific intervals for a period of 24 hours after biopsy. Hemoglobin and hematocrit levels were measured at 10 and 20 hours after biopsy.

Results

Liver tissue was recovered at biopsy in all 30 attempts made. Histological analysis of the tissue obtained helped, either directly or in conjunction with other clinical procedures, to clarify the clinical suspicion. The morphologic diagnoses obtained can be grouped as follows: cirrhosis (various types), 7 patients; hepatitis, 11 patients (chronic active in 6 patients, alcoholic in 5 patients); and miscellaneous diagnoses in 12 patients.

Blood pressure and pulse remained stable in all patients during the 24 hours following liver biopsy. Only one patient complained of pain. This was located at the site of biopsy with radiation to the right shoulder region, occurred immediately after

* Clinical Assistant Professor of Medicine, Emory University School of Medicine. Dr. Ravry's address is Suite 607-A, 478 Peachtree St., N.E., Atlanta, Ga. 30308.

biopsy, and was relieved by mild non-salicylate analgesics. The hemoglobin and hematocrit remained stable for 20 hours following biopsy in all but one patient. Without adequate explanation, this elderly patient had already been demonstrated to have a 1-gram% decrease in hemoglobin since admission to the hospital and prior to liver biopsy. Over the 24-hour period following biopsy, her hemoglobin decreased further by 3 grams%. She responded uneventfully and stabilized with transfusion of two units of packed red blood cells. There were no deaths in this group of patients and no patient required a laparotomy.

Comment

Liver biopsy is a relatively safe and useful diagnostic procedure for the study of liver disease. Multiple needles and modifications of existing procedures have been advocated since the first attempts at diagnostic aspiration of liver tissue at the turn of the century.[1] Yet, only two needles continue to be used with most frequency: the Vim-Silverman and the Menghini needles. The advantages and disadvantages of each type of needle have been discussed elsewhere.[1] The recently introduced Tru-Cut needle is only a modification of the Vim-Silverman needle which incorporates all of its essential features into a single-piece instrument. This assures increasing speed and ease of performance while retaining all the other advantages (particularly the higher diagnostic yield in cirrhosis) of the Vim-Silverman needle. Furthermore, the Tru-Cut is disposable, a fact which would serve to reduce the potential risk of transmitting viral hepatitis by the use of reusable biopsy needles.

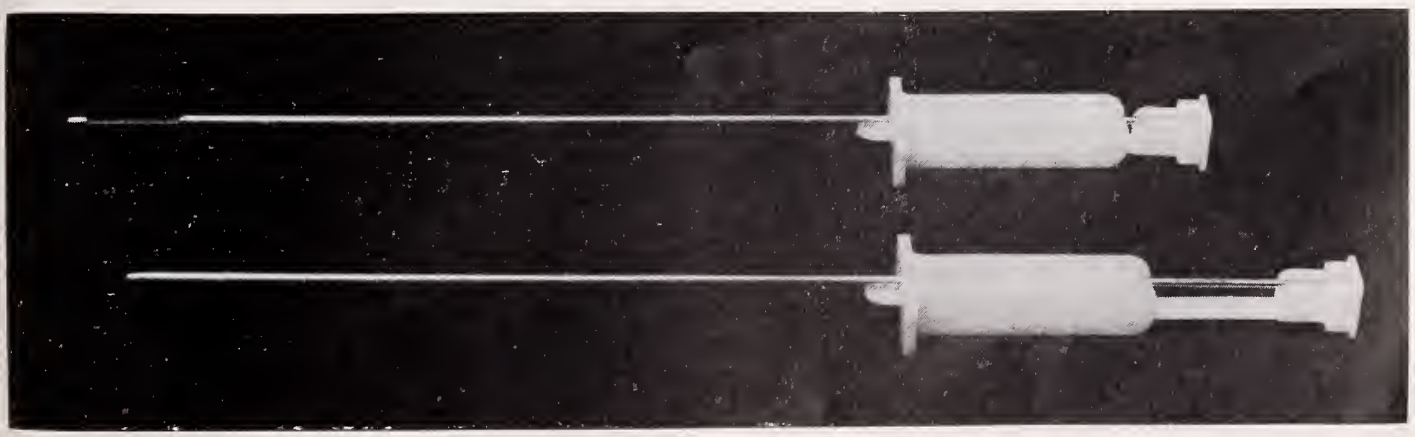
Although the author is aware of multiple centers using the Tru-Cut needle for percutaneous liver biopsy, reference to its use for liver biopsy in the published literature is scanty. McGill and associates[3] reported in 1974 the use of a disposable cutting needle for the performance of 619 percutaneous liver biopsies at the Mayo Clinic. The disposable needle referred to by these investigators was the Tru-Cut (personal communication). In their experience, 4% of the patients experienced some degree of pain (from mild to severe), and 2% of the patients experienced a decrease in hemoglobin of one to two grams. They demonstrated that liver biopsy with this needle could be performed relatively safely as an out-patient if hospital facilities were immediately available. More recently, Kondi and Gallitano[2] reported that liver biopsy using the Tru-Cut was a safe and easily performed procedure. They experienced no complications in 40 percutaneous liver biopsies using the Tru-Cut through an anterior approach. I have been unable to find any published studies comparing the different needles and/or techniques in a controlled manner.

Our experience, although limited, confirmed the simplicity and improved ease of performance of liver biopsy using the Tru-Cut. The complication rate in the present small series was similar to that of McGill and associates.[3] Furthermore, the Tru-Cut appears to be as reliable as the Vim-Silverman needle for the morphologic diagnosis of cirrhosis. These characteristics, added to its disposability, make the Tru-Cut ideal for percutaneous needle biopsy of the liver.

Addendum: Since submitting this article for publication I have performed an additional twenty percutaneous liver biopsies in a similar number of patients, using the Tru-Cut. All attempts were successful in obtaining liver tissue for examination. Only two patients complained of discomfort (in the right shoulder). No other complications were observed.

REFERENCES

1. Edmondson, H. A. and Schiff, L.: "Needle Biopsy of the Liver," Chapter 9 in *Diseases of the Liver,* Leon Schiff, Editor. Philadelphia, Pa., J. B. Lippincott Co., 1975, p. 247.
2. Kondi, E. S. and Gallitano, A. L.: "The Anterior Approach to Percutaneous Liver Biopsy," *Surg. Gynec. Obstet.* 140:422-424, March, 1975.
3. McGill, D. B., Ott, B. J. and Taylor, W. F.: "Liver Biopsy: Comparison of Risks in Out-patients and In-patients," *Gastroenterol.* 67:A-37/814, October, 1974 (Abstract).
4. Revised Instructions for Use of Tru-Cut® Biopsy Needles. Deerfield, Illinois, Travenol Laboratories, Inc., January, 1975.



The disposable Tru-Cut® biopsy needle in the open and closed positions.

Problems in health care as seen from the viewpoint of a hospital administrator.

Decision Making in Health Care

EDWARD J. FECHTEL, JR., *Athens**

I AM DELIGHTED to be here today, and I have accepted, as quite a challenge, the job of presenting my observations on the financial and institutional factors involved in medical decisions. It is a challenge because I have been advised that my audience would be composed of physicians, nurses, and other health professionals. I presume that there are very little financial and institutional factors that are not fully known to you other than perhaps those very intricate, detailed financial matters that even administrators have difficulty in grasping.

During my talks as President of the Georgia Hospital Association, I have been asking all administrators, physicians, and other health professionals to pause for a moment and return to a review of the fundamental concepts about health care delivery. Recalling the words of Sydney Smith, we are told, "It is the calling of great men not so much to preach new truths as to rescue from oblivion those old truths which is our wisdom to remember and our weakness to forget."

There are many prophets, or shall I say, preachers of new truths running around our health care system some extolling the horrors, and some pronouncing the virtues, of the Health Systems Agencies under P.L. 93-641, PSROs, National Health Insurance, the regulatory powers of federal and state governments and so forth.

What I want to do today with our subject matter is to examine from a very rational perspective, those old truths.

What we have to offer represents a basic need of humanity—health care. We operate in a highly civilized society in which the right to have access to health care has been widely accepted. Nobody is going to come up with a better answer than a hospital to provide acute patient care. Such a society as ours will not allow itself to impair its own ability to deliver effective health care and reduce mortality and morbidity through its health professionals and health care institutions. Part of the reason for increased health care cost is the pressure to adhere to higher standards of operation than before. Thus, more staffing, more equipment, etc.

But continuing on with the review of the old truths—the physician has always been the central figure in health care and no doubt will continue to be. Nothing happens in a hospital without a doctor. No patients are admitted; no services are performed. Dependence upon the physician to make things go is supreme, although there are trends and other developments creating a sharing with other health care professionals in initiating hospital services.

There has been a change in the dependence of the physician upon the hospital, however; this has evolved into a very delicate and intricate dependency of both the institution and the physician upon one another. This dependency and the way in which it is handled is crucial to the effectiveness and efficiency of health care delivery in the institutional setting.

Whereas the institution depends upon the physician who has the education and the statutory authority to order treatments, prescribe medications and so forth; conversely, the physician depends upon the hospital for, among other things, high quality services, convenience of his professional practice, modern diagnostic equipment, a source of continuing education, advice about patient needs, admission of patients on the basis of medical need and not ability to pay, etc.—all of this to be provided at a reasonable cost to the patient.

Another one of the "old truths" is that professional judgment is still as much a part of health care delivery as it ever was. We have allowed society to classify us as persons and institutions that always have the right answer, always do the right thing, and

* Administrator, Saint Mary's Hospital and Immediate Past President of the Georgia Hospital Association. Mr. Fechtel's address is 1230 Baxter St., Athens, Ga. 30601. Presented at the Institute on Decision Making in Health Care, Oct. 16, 1976, at the Century Center Hotel in Atlanta.

never make an error. As society sees us more and more as the guarantor of a good outcome, the concept of judgment is being lost. Many nurses want an answer to difficult problems in terms of their exposure to tort liability rather than be told to exercise their best judgment in patient care decisions.

However, if we are to correctly understand the financial and institutional factors in a hospital, we must always remember that they revolve around the professional judgment of all health care professionals. With respect to the judgments of the medical staff—the problem is that it is that judgment which is now being tested.

The professional judgment of a physician is being tested by those who pay for the medical care using the concept of "medical necessity." It is being further tested by the availability of services at the hospital and the number and variety of modern diagnostic devices and the availability of qualified consultants to assist him in the formation of that judgment.

In other words, in the exercise of his judgment as to what a patient needs or does not need, there is the inevitable frustration as to the degree to which the physician can depend his prescribed services will be carried out by others to the extent he desires as well as the availability of the assistance he needs to diagnose and treat his patient. Thus, we get into the factors of the staffing pattern of the hospital, the level of training of hospital personnel, as well as the effective organization of all ancilliary services to carry out the job of patient care. The adequacy of diagnostic and treatment equipment and supplies, of course, is a must. No doubt this is a point of frequent discussion between medical staff and hospital staff.

Irrespective of the quality of the medical judgement and other factors, there is the limitation of privileges. The obtaining and maintaining of privileges in an institution is crucial to what a physician can or cannot do in a hospital. The nature and extent of privileges generally depend upon a physician's training and competence and the method of granting and reviewing privileges arise out of the Joint Commission Standards, the hospital medical staff bylaws, policies, rules and regulations, and the composition of the medical staff.

If this is not enough, then there is a multitude of other Joint Commission Standards, federal regulations such as Medicare and state regulations such as licensure requirements imposing limitations either upon the physician or the institution.

Now let us step back and take another look at these limitations for a moment. Many of the limitations now being experienced and those that will be experienced in the future are those arising out of standards, regulations, and court decisions imposed upon the health care institution which in turn affects the degree of freedom which the physician has in order to work within the institutional setting.

The administrator and the board of trustees of the hospital also feel these restrictions. Their freedom to make real decisions relating to the provision of health care are diminished. Institutions must examine and abide by Medicare regulations, licensure regulations, and an overwhelming mass of other laws and regulations and court decisions which now govern hospitals, constantly staying in touch with the hospital's attorney t determine what is legal.

We sometimes wonde. if we have the ability to make true decisions in its purest sense and what we have more and more is a quasi military system of "operating by the book." We have become more accustomed to saying, "Will Medicare permit this?," or "Will the Joint Commission let us do thus and so?," irrespective of whether or not it is in the best judgment of the physician, the administrator, the board, or anyone for that matter.

As society focuses upon health care as a matter of great interest to it and desires to obtain more influence, the institution becomes the locus of all of the pressures to institute changes in our health care delivery systems and this is where physicians feel this pressure more acutely. As this pressure continues, the obvious stress that it will create will get worse.

The financial factors in health care delivery in our institutions are truly another pressure point in this medical decision making and the judgement which the physician exercises. There is the question of whether or not the hospital has the financial resources to provide the diagnostic procedures or the staff with sufficient technological and professional skills to provide the level of service needed by the medical staff. As hospitals become sophisticated in their diagnostic and treatment and provide more skilled staff in greater numbers hospital costs necessarily go up. The only thing which has helped contain hospital costs in view of the fact hospitals are offering more intense services, is that patients leave the hospital sooner. The corresponding reduction in length of stay tends to lower the overall cost. In studying the financial implications of health care in our institutions today, it is important that we always analyze the hospital cost situation in terms of the cost per *stay* as opposed to the traditional cost per *day* calculation.

The cost per *stay* is being lowered because of better discharge planning procedures and mandated utilization efforts. Social service departments which are now required by the Joint Commission in all of our hospitals many times can prepare the way for the patient's discharge back to a suitable environment in a much more prompt and effective way than we had in the past.

The availability of better equipment, drugs, and techniques obviously brings patients to the point they can leave the hospital sooner. Earlier discharge is further enhanced by the availability and effectiveness of patient education programs which help the patient leave sooner and avoid readmissions. Availability of nursing home beds and home health care programs also are factors with respect to continuing health care delivery outside of the institutional setting at a lower cost.

Most hospital care is financed by insurance, whether it be Blue Cross or so called commercial plans, or those governmental plans such as Medicare and Medicaid. The inevitable problem is that as the cost of health care goes up, it may or may not be passed directly to the patient. Rather, it may be passed to the employer or to the taxpayer through higher premiums.

The former Executive Vice President of the American Hospital Association, Larry Hill, told me that he understood the concern expressed by the automobile industry when they explained to him that the cost of providing health insurance for their employees had equaled the cost of the steel which went into the average passenger automobile they manufacture. This concern was shared by the union as they see more dollars being put into health insurance coverage reducing the industry's ability to put those dollars into the pockets of their members.

Of course, as hospital costs go up so do hospital charges and these charges can only be kept low by increasing volume of service. Physicians are obviously caught in a three way dilemma when asked to help the cost situation by limiting their prescriptions of tests and treatments to "medical necessity." There is pressure brought from the trends in professional liability suits which enhance the tendency to prescribe when in doubt rather than rely solely on judgment in a patient workup. The hospital administrator obviously confronted with large investments in overhead, personnel, and equipment needs to see such heavy utilization by the medical staff and not respond to cost containment advocates fearing decreased subsequent loss of income.

In any event, most hospitals are able to finance most diagnostic and treatment requests of a physician. We are entering an era, however, as you know, in which duplication of service and unnecessary costs is being mentioned more and more.

I see that society is becoming more cognizant of the fact that we have limited resources to fill unlimited needs and questions of priority will prevail. We simply cannot afford to provide everything that we want. Requests for new services and equipment will be subjected to financial feasibility analysis to determine if the hospital can recover its investment. The capital expenditure reviews, as you know, are required by the Medicare regulations and those reviews that may be required by any future certificate of need legislation.

To examine one of those "new truths" for a minute. The physician's ability to exercise his judgement without consideration to the "medical necessity" or other financial factors may change more drastically under a new national health insurance program, but this depends entirely upon the nature and extent of that program. It will also change to some degree when a PSRO program is fully implemented in the state. No doubt PSRO will become the largest single factor in future decisions about institutional care as they are scrutinized from the context of "medical necessity." This "medical necessity" will extend beyond the mere review of admissions and length of stay into individual treatment orders as I see the full implications of PSRO.

The one thing that I would like to say in closing is that I think that there is a clear mandate to Washington and our State capitol that if they expect to have good health care delivered as effectively and efficiently as possible for each citizen of the United States and the State of Georgia then they had better listen more closely to those of us who have the job of providing their care. ■

ASK MEDICARE

Q: "Why does our bookkeeper get phone calls from Medicare about my office consultations with patients?"

A: "For Medicare purposes, a consultation is a professional service furnished by a second physician at the request of the attending physician. A claim submitted for reimbursement of a consultive service must state the name and address of the referring physician. If this information is missing a phone call is required. According to a recent tally we make 80 to 100 such calls per day. Results indicate that 26% of the services are office visits or physical exams and not, strictly speaking, consultations."

Q: "Is there any expeditious way for us to mail Medicare claims?"

A: "Yes, a special post-office box has been reserved to receive claims from physicians' offices, and a supply of large pre-addressed envelopes is offered for use in submitting the claims. Since these envelopes are designed to hold up to 75 unfolded, single sheets and are fairly expensive we ask that they be used only for sending sizeable accumulations of claims."

The address for physicians' and other providers' claims is: Prudential Insurance Company, P.O. Box 98157, Briarcliff Station, Atlanta, Georgia 30359.

Cystoid Macular Edema after Intracapsular Cataract Extraction and Phacoemulsification

WILLIAM S. HAGLER, M.D. *and* THOMAS P. MANCHESTER, M.D., *Atlanta**

Clinical experiences with thirty-three cases are discussed.

Cystoid Macular Edema ("CME") is the most common and troublesome complication following cataract surgery. It is hard to diagnose with the ophthalmoscope. The vitreous is usually hazy at the posterior pole and one may recognize only the loss of the foveal reflex. Occasionally one sees a yellowish spot or typical multiocular edema around the fovea, especially if the posterior pole is examined with a retinal prism.

The history is sometimes helpful. The patient may have good vision a few weeks after surgery and then return to the office later to find that the vision has dropped several lines on the eye chart.

The presence of CME can be detected very accurately if one performs fluorescein studies. There is a leakage of dye in a circular fashion in the macula which progresses to produce a diagnostic dark stellate figure in the background of fluorescein staining as the dye fills the cystic spaces. Sometimes there is diffuse leakage of dye into the vitreous from the vessels of the disc and into the aqueous from the vessels of the iris[1, 2] (Fig. 1).

The frequency of significant CME after cataract surgery is about 50 percent. Jaffe felt that some CME might be found every time if the fluorescein studies are done often enough in each case.[3]

Some ophthalmologists feel that SME is less likely to develop if the posterior capsule is left intact at the time of surgery, recommending either phacoemulsification or simple extracapsular extraction.[4-7] There is as yet no reliable research reported to confirm or deny this theory.

At the recent meeting of the Kelman Society, Winslow and associates reported finding CME in 12 percent of 113 cases of phacoemulsification and in 13 percent of 52 cases of intracapsular extraction (about the same in both groups).[8] Hurite reported his study of 100 cases of phacoemulsification alone in which 22 percent developed CME.[9] Capsulotomy had been done on one-third of the cases which developed CME and on one-third of those which did not develop CME. He concluded that capsulotomy did not seem to increase the incidence of CME.

Recently we have been following a group of patients in which some have been given intracapsular surgery and others have been given phacoemulsification. Dr. Ed Norton recommended to us that the dye injections be given at four months and later at sixteen months after surgery, in order to be dealing with amounts of edema great enough to have some clinical significance.[10]

Procedure

At an interval of four months postoperatively, the eyes were examined gonioscopically for the presence of vitreous in the wound and then the pupils were dilated for funduscopic examination, following which, fluorescein studies were done. In the beginning, a few cases were injected at two months postoperatively.

Intracapsular Extractions

Twenty consecutive cases of routine intracapsular extractions were studied (Chart 1). In one of these, an anterior vitrectomy had been done because vitreous presented. In three more cases, vitreous was found to extend through the pupil and up toward the wound postoperatively. These three cases seemed to be uncomplicated at the time of surgery. The pupils were round and it had been assumed at operation that the anterior hyaloid was intact. Four other cases had mild iritis for several weeks postoperatively. The iritis was controlled by the instillation of local steroid eye drops. Cystoid macular edema was present in six cases out of the twenty eyes subjected to intracapsular surgery.

* Suite 260, Piedmont Professional Building, 35 Collier Rd., N.W., Atlanta, Ga. 30309. This paper was presented at the Interim Meeting of the Georgia Society of Ophthalmology in Atlanta, November 20, 1976.

Phacoemulsification

Thirteen consecutive cases of phacoemulsification were studied and in one of these the posterior capsule had been torn, vitreous was lost, and then an anterior vitrectomy had been performed. There were no visible vitreous strands extending to the wound in any of the phacoemulsification cases. Two eyes developed CME.

One complication was conspicuous and should be considered. This was the disturbance in visibility of the fundus due to capsular material in the pupil. It was very noticeable in six out of thirteen cases.

Cystoid Macular Edema

CME was present in a total of eight cases (Chart 2). Of the twenty eyes having intracapsular cataract extraction, six developed the condition and of the thirteen having phacoemulsification, two developed it. In other words, about 30 percent of the intracapsular cases and 15 percent of the phacoemulsification cases had CME. The number of cases, however, is too small for any statistical significance. CME developed in both of the two cases which had vitrectomy.

Associated Factors

Age may have been very important. Our intracapsular cases averaged 75 years and our phacoemulsifications averaged only 53 years. The average age of all patients with CME was 76.

Eye color has been said to be important.[11] Patients with blue eyes seem to be especially vulnerable, but three of our eight cases had brown eyes.

Iritis may be an important factor in the causation of CME.[12] Only two of our eight seemed to have any evidence of postoperative iritis and these were very mild cases.

Vitreous loss at the time of surgery predisposes the eye to the complication of CME.[13] In the thirty-three cases of cataract surgery, there were two in which vitreous was lost and an anterior vitrectomy was necessary. Both of these eyes developed CME.

Binkhorst has said that exposure to the sun postoperatively may cause the eye to develop CME.[14] None of our aphakic patients has been protected from the sun; however, this may be advisable in the future.

The level of vision is sometimes quite good even in the presence of CME. Five of our eight cases had vision of 20/40 or better. One had 20/50, one had 20/100 and only one had 20/200.

Epinephrine eye drops have been known to cause CME.[15] Likewise, nicotine acid produces a maculopathy, although not exactly similar to that which characteristically follows cataract extraction. Possibly phenylephrine could play a part in the development of CME postoperatively. None of our cases were given any of these drugs, except occasionally during the process of dilating the pupils for a routine postoperative examination in the office.

Some cases of CME after cataract extraction have been associated with retinal hemorrhages toward the six o'clock meridian, perhaps due to trauma at the time of surgery.[16] We did not find this in our cases.

As previously mentioned, dye leakage around the disc and from iris blood vessels is often conspicuous in association with CME. We often found evidence of dye leakage around the optic nerves and into the vitreous.

Discussion

Cystoid macular edema seemed less frequent after phacoemulsification than after intracapsular extraction. However, our series was quite small, and the cases undergoing phacoemulsification were usually about two decades younger than the intracapsular cases.

We were impressed with the fact that ophthalmoscopy was unsatisfactory in many cases following phacoemulsification, due to the presence of a posterior capsule in the eye. A diagnosis of CME may often be impossible without the use of fluorescein studies. From this we have derived a simple rule: never perform a capsulotomy for poor vision postoperatively until after fluorescein studies have been done to rule out the presence or absence of CME.

How one might attempt to reduce the likelihood of CME developing after cataract extraction:

1) Make the surgery as atraumatic as possible with a minimum of intraocular manipulation and irrigation, because the presence of inflammation makes the complication of CME more likely. Postoperatively give local steroids to reduce the iritis. Asector iridectomy may decrease the pull of the pupil on vitreous and may prevent delayed rupture of the hyatoid face.

2) Never use epinephrine, phenylephrine or nicotinic acid.

3) Avoid disturbance of the vitreous at all cost.

4) Protect the eyes from sunlight for six months postoperatively.

5) We cannot recommend preferential removal of the cataract by phacoemulsification, because this procedure is associated with: more irrigation and manipulation within the eye; iritis from retained lens matter, and probably more frequent disturbance of the vitreous.

Summary

Out of twenty eyes recovering from intracapsular cataract extraction, six developed cystoid macular edema. Of thirteen eyes recovering from phacoemulsification, two developed cystoid macular edema. The latter group was much younger than the former.

CHART 1

TYPES OF CATARACT SURGERY

	Intra-capsular	Phacoemul-sification
Cases Studied	20	13
Age range	66-87	18-71
Average age	75	53
Vitreous to wound by gonioscopy	3	0
Vitrectomy	1	1
Iritis	4	0
Fundus poorly seen	0	6
Cystoid maculopathy	6	2

CHART 2

CYSTOID MACULAR EDEMA

Total	8/33-24%
Intracapsular	6/20-30%
Extracapsular	2/13-15%
Age	average 76
Brown eyes	3/8 -37%
Iritis	2/8 -25%
Anterior vitrectomy	2/2-100%

REFERENCES

1. Wise, Dollery and Henkind: *The Retinal Circulation.* Harper and Row, New York, 1971, p. 182, 360.
2. Koltow, M. and Hendrickson, P.: "Cystoid macular edema." *Arch. Ophthal.* 93:487-493, July, 1975.
3. Jaffe, S. J.: *Cataract Surgery.* C. V. Mosby Co., St. Louis, 1976, p. 282.
4. Binkhorst, C. D.: *Highlights of Ophthalmology.* Panama 1, R.P. Clinica Boyd-Panamerican Institute of Ophthalmology, 1975-1976, p. 295.
5. Hirschman, H.: Miami Symposium on Intraocular Lenses, December 7, 1975.
6. Kratz, R.: Ibid.
7. Gas, D.: Ibid.
8. Winslow, Harris and Taylor: *Cystoid Macular Edema After Phacoemulsification and Intracapsular Cataract Extraction.* Annual Meeting of Kelman Society, October 6, 1976.
9. Hurite, F.: *Cystoid Macular Edema and Phacoemulsification.* Ibid.
10. Norton, E.: Personal communication, 1975.
11. Worst, J.: *Highlights of Ophthalmology.* Panama 1. R.P. Clinica Boyd-Panamerican Institute of Ophthalmology; 1975-1976, p. 272.
12. Irvine, A. R.: "Cystoid maculopathy." *Survey Ophthal.* 21:1-17, July, 1976.
13. Jaffe, S. J.: op. cit.
14. Binkhorst, C. D.: op. cit.
15. Irvine, A. R.: op. cit.
16. Wise, Dollery and Henkind: op. cit.

MAG SPONSORS EDUCATION FOR RESIDENTS

How much does it cost to set up and run a medical office? Where can I get the money? Should I go into solo practice, partnership, or group practice? How can I hire the best office assistants? What system should I use for scheduling patients, billing, patient records?

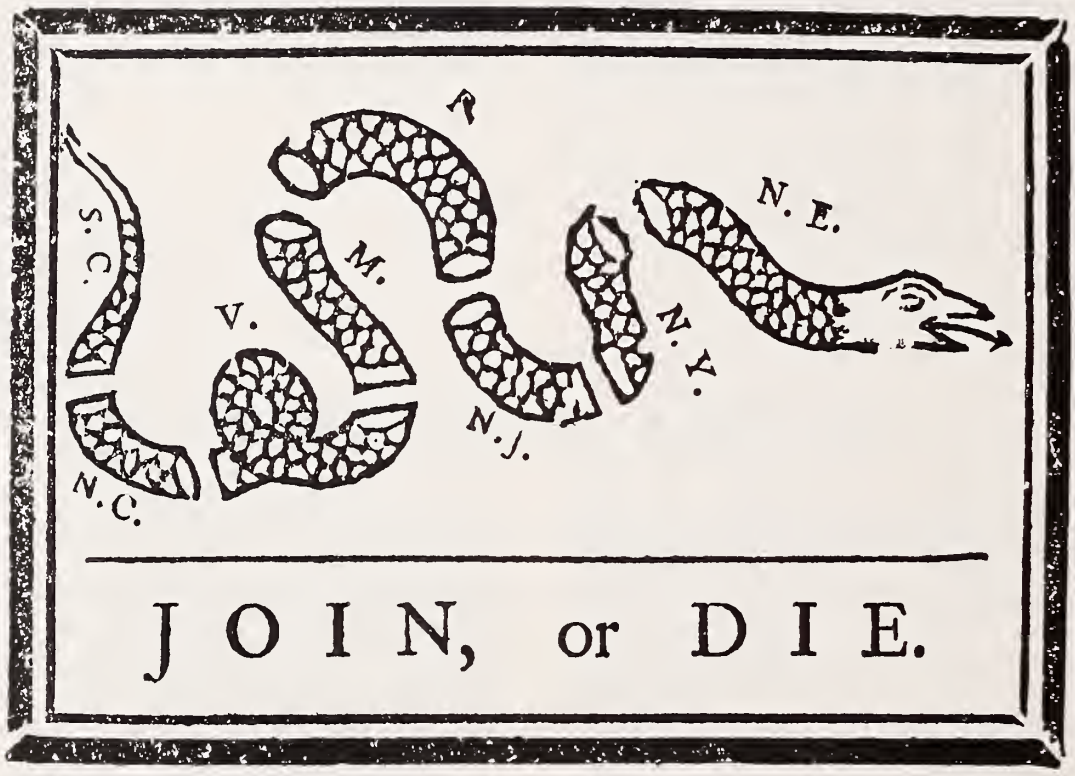
Such mundane questions are not taken up in the normal medical school curriculum, nor is there usually time for them amid the bustling hospital activity of residency training. Yet the young resident about to embark on a career of private practice fears shipwreck at the start. How will he or she be not only a good doctor but an instantaneous success as employer, manager, handler of money, and community relations expert? The MAG has been building a tradition of providing education which meets this need.

1977 marks the fourth consecutive year that the MAG has co-sponsored, with the AMA, a Practice Management Workshop for residents, conducted by experts from Conomikes Associates, a California firm specializing in practice management consultation. Columbus, Georgia's Airport Holiday Inn provided the site for a workshop on February 22-23. The 29 participants, three wives, two educators and MAG's Director of Education (Dr. Stephen Daniel) began the workshop by getting acquainted. Seventeen of the young physicians were doing their residencies in Georgia, eight in Alabama, two in Tennessee and one each in Florida and South Carolina. Specialties represented included family practice, internal medicine, obstetrics-gynecology, pediatrics, gastroenterology and general surgery. Over half of the group planned to go into practice during the coming year, in such locales as Dublin, Forsyth, Augusta and Blue Ridge in Georgia; Tallahassee, Florida; Baton Rouge, Louisiana; rural northern Alabama; Mississippi; Virginia; and even far-off Chico, California.

The group turned readily to business—the business side of medicine. For two days everyone joined actively in the give-and-take of discussion, and the exchange continued into lively talk around the lunch table and over evening drinks in the lounge. No one left the workshop early—a rarity for meetings of doctors, and a strong indication of success. As with previous workshops, the best publicity the MAG gets for this educational activity is the enthusiasm of those who have made the workshop. Word gets around.

The success of the workshops has led MAG planners to consider sponsoring two or three per year, held in different cities. Plans for the 1977-78 academic year call for a workshop in early 1978 and perhaps as soon as the late fall or early winter. If you are a resident and are interested, you may contact MAG's Director of Education, (404) 876-7535.

—S.L.D.



Franklin's original snake, 1754.

Ophthalmologists and MAG Join Forces

THIS WAS AMERICA'S first political cartoon, which appeared on May 9, 1754 in the *Pennsylvania Gazette*. It was drawn by Benjamin Franklin to support his "Plan of Union" for the colonies and was based on the popular superstition that a snake that has been severed would come back to life if the pieces were put together before sunset.

No, I do not believe that Mr. Franklin was thinking of the Aesculapian serpent when he set out to draw this historical work. But, the moral seems to apply to us today. Medicine is being hacked at by an ever-increasing barrage of legislative encroachments. These are almost always well-thought-out plans by non-medical or para-medical groups wishing to enter the field of medicine. They are aided by apathy and poor organization on our part.

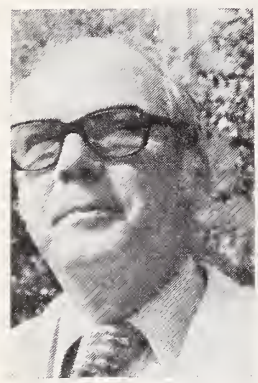
This was acutely brought to my attention when the Optometrists entered S.B. 20 in our 1977 legislative session. This would allow optometrists to use drugs, that is, become doctors by legislation. Other specialty societies have similiar problems, as the psychiatrist with the psychologist, the orthopaedist with the podiatrist, and we all face the professional assistant who must be controlled if the public interest is to be served.

Approximately sixty-seven bills related to medicine were presented in some form during the last legislative session. Only with the help of MAG members (other than Ophthalmologists) and the MAG staff was it possible to divert Senate Bill 20 into a study committee. This bill will be with us throughout this year, however, and into the next.

It would seem that further consideration should be given by us all towards combining our specialty legislative efforts through MAG. Collectively, we are 4,400 strong, and represent an unquestioned potent political force, if properly activated. Yes, we have our apathy, and perhaps even an occasional Tory in our ranks, but the call for a "Plan of Union" rings too clearly.

Roger R. Rowell, M.D.
President-Elect
Georgia Society of Ophthalmologists
542 Church St.
Decatur, Ga. 30030

president's letter



Don't Forget Our Purpose

IT IS WITH GREAT HUMILITY that I approach this first of my communications to you. The honor that you have bestowed upon me is beyond my description. I trust I will not fail you and, in turn, ask for your help in moving MAG forward in the pursuit of our stated purposes.

We must never forget that our primary purpose is to work to improve and protect the medical care for the people of our great state. This has become much more difficult because of the intervention in our professional affairs by the federal, state and local government bureaucrats and social planners.

Those of you who have not read the report written and submitted to the Secretary of the Health, Education and Welfare Department, Mr. Joseph Califano, by Mr. Ralph Nader's Health Research Group directed by Sidney M. Wolfe, M.D., should obtain a copy from your MAG Delegate and read it in its entirety. When you have done that, I am sure you will be aware of the hazards ahead and the difficulties of the task that we have. I do fervently believe we can be successful as long as we remain united as physicians and do not lose sight of our stated purpose.

Again, my appreciation for the great honor you have bestowed on me.

Cordially yours,

Robert E. Perry Jr., M.D.
President-Elect, Medical Association of Georgia

I've told this before . . .

(Editor's note: A neighbor learns the value of good fences in this anecdote from Dr. McDaniel. Others wishing to contribute to this page should send their stories to the Journal of the Medical Associaiton of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Flag Man at the Nursing Home

RECENTLY I HAD occasion to visit a nursing home in one of our small towns near Atlanta. It was owned and operated by the same man, which is unusual.

I "got to talking" with an old man who was a resident in the home. The more we talked, the better I liked him. He was eightyish, had early Parkinsons, a noticeable tremor at times. He seemed to enjoy life and took great pride in being the flag man—that is, raising and lowering the flag each day that the weather was clement. During our conversation, his mind seemed clear as a bell, but the nurse told me that occasionally he gets confused as to time and place and reverts back to events of long ago.

Upon taking leave, I went by to see Mr. Whigham, the owner, and during our conversation I mentioned the fact that I had had an enjoyable chat with an old man that everybody called Jonah.

"Oh, Johnathan," said Mr. Whigham. "Jonah is one person we couldn't do without. He is assigned odd jobs, enjoys executing them and helps tremendously in keeping up the morale of the other residents. If you have a minute, I'll tell you an interesting story about Jonah.

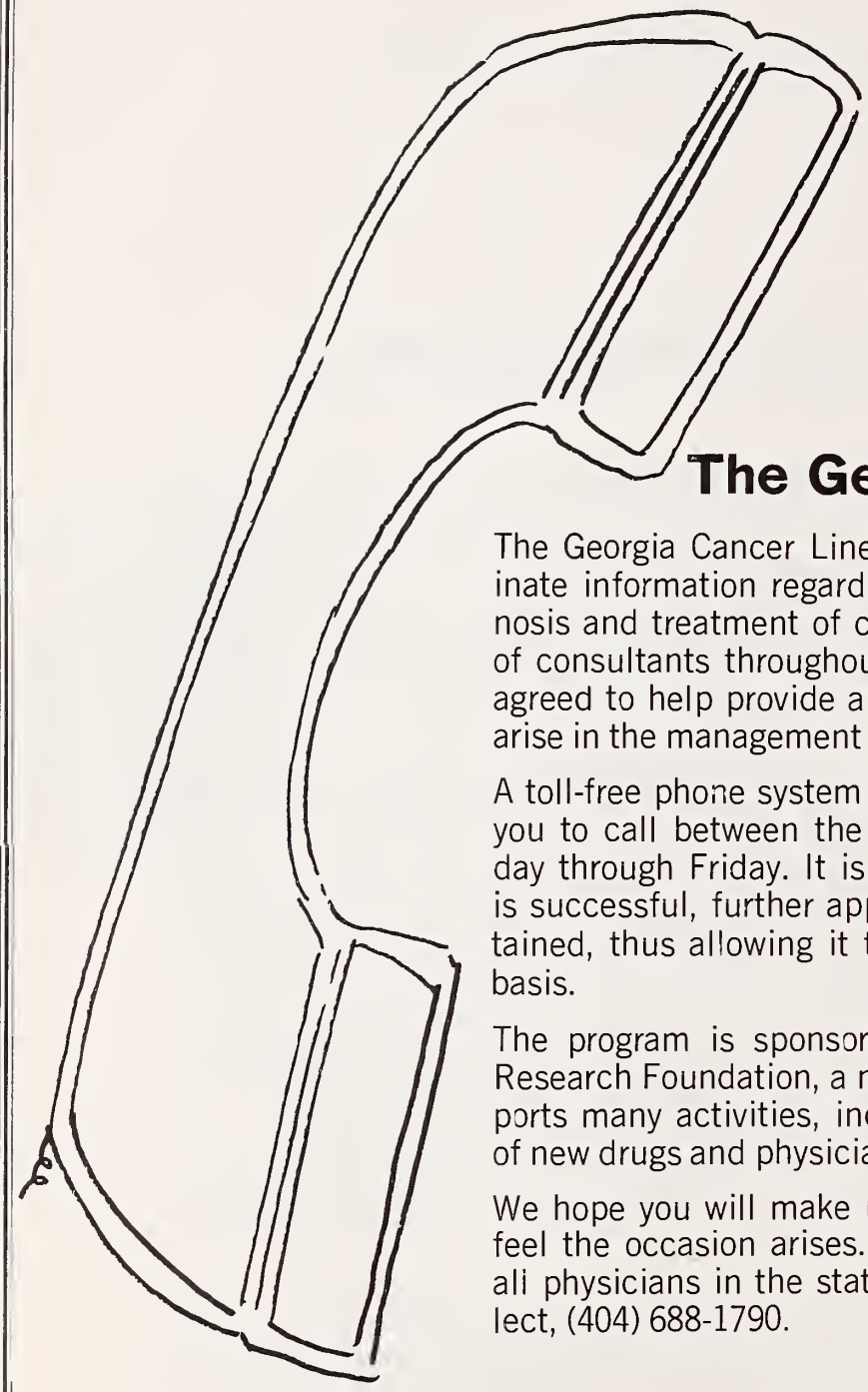
"I built this place about four years ago," said Mr. Whigham. "After about a year, I wanted to build a fence around the sides and back of the building for the reason that some of our clients take a notion every once in awhile to wander off. And if the only way they could get out of the yard was by the front, they would more than likely be seen by someone and save us some embarrassment. But my neighbor, Mr. Buck, did not especially like the idea. He said that he just didn't like a fence in the first place, and then, too, he would have to plant shrubbery or flowers to hide it.

"Time went by and last year Mr. Buck, who is an elderly widower, came home from town about 11 o'clock one morning. Upon opening the front door, the first thing he noted was the unmistakable smell of bacon cooking. He dashed back to the kitchen, flung open the swinging doors and there sat an old man at the kitchen table eating fried eggs and bacon and bread. . . .

"It was a confused and disoriented Jonah. He had not been able to find the silver and was using a kitchen spoon to eat with and a butcher knife as a pusher. When Mr. Buck entered, Jonah stood up immediately, held the big butcher knife in his right hand and his palsy caused it to tap on the table. He fastened his eyes on Mr. Buck and asked in a strong, tremulous voice, 'What in the hell are you doing in my kitchen?' And Mr. Buck, of course, went back out of the front door faster than he came in.

"And that's how it came to pass that a fence was built and that's ole man Buck you see out there now cheerfully nurturing roses and shrubbery that he is growing along side of it."

J. G. McDaniel, M.D.
820 W. Wesley Road, N.W.
Atlanta, Georgia 30327



The Georgia Cancer Line

The Georgia Cancer Line has been developed to disseminate information regarding recent advances in the diagnosis and treatment of cancer. We have enlisted a group of consultants throughout the state of Georgia who have agreed to help provide answers to questions which might arise in the management of cancer cases.

A toll-free phone system has been set up which will allow you to call between the hours of 9 am and 5 pm, Monday through Friday. It is hoped that if this pilot program is successful, further appropriate sponsorship can be obtained, thus allowing it to be continued on a permanent basis.

The program is sponsored by the Southeastern Cancer Research Foundation, a non-profit organization which supports many activities, including clinical research, testing of new drugs and physician education projects.

We hope you will make use of this system whenever you feel the occasion arises. The Cancer Line is available to all physicians in the state. All you have to do is call collect, (404) 688-1790.

Sponsored by
The Southeastern Cancer Research Foundation
P.O. Box 54777, Atlanta, Ga. 30308
(404) 688-1790

Call Collect

(404) 688-1790

Report on Liver Tumors and Oral Contraceptives

GERALD P. MURPHY, M.D., F.A.C.S.*

(*The following report of the Commission on Cancer of the American College of Surgeons is of sufficient importance to be reproduced herewith for all physicians in Georgia.*—LaMar S. McGinnis Jr., M.D., Chairman, Professional Education Committee, American Cancer Society, Georgia Division, Inc.)

PRELIMINARY DATA from a survey by the American College of Surgeons' Commission on Cancer tends to support an association between liver tumors and oral contraceptive use, at least for benign tumors.

As of December 15, 1976, 369 hospitals had reported a total of 453 primary tumors among both sexes in the six-year period 1970-1975. Of these cases, 149 tumors were found in males; 91.3% (136) were malignant, and 8.7% (13) were benign. A different diagnostic pattern was evident in 304 tumors found in females; 56.9% (173) were benign, and 43.1% (131) were malignant. A substantial difference was observed in the proportion of benign to malignant tumors among oral contraceptive users (75.7%) as compared to non-users (49.1%).

This body of information, the largest material on benign liver tumors available to date, was collected by the network of State Liaison Fellows and participants in the Field Liaison Program. The National Cancer Advisory Board, concerned with increasing reports suggesting an association between use of oral contraceptive agents and development of liver tumors, had appealed to the Commission on Cancer to determine the extent of the problem. Dr. Gerald P. Murphy, Chairman of the Committee on Patient Care and Research, reported the preliminary findings on November 15 to the Board, demonstrating the timely and effective use of the field liaison network. The findings cited from the survey to date are:

1. Benign liver tumors are very rare in males.
2. A substantial difference was observed in the proportion of benign to malignant tumors among oral contraceptive users compared to non-users. The greater proportion of benign tumors among oral contraceptive users was consistent in all age groups. These results support the suggested association between oral contraceptive use and benign liver tumors.
3. Benign liver tumors were diagnosed in non-users of oral contraceptives. Among non-users, the frequency of benign tumors increases with age.
4. Hepatic cell adenomas and focal nodular hyperplasias were observed more frequently among oral contraceptive users than non-users.
5. Intraperitoneal bleeding was a presenting symptom in hepatic cell adenoma in 12% of cases.

* Chairman, Committee on Patient Care and Research, Commission on Cancer, American College of Surgeons. Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

6. The data collected on type of contraceptive used and duration of usage in this survey do not lend themselves to conclusive analysis.

A more thorough report is in preparation for publication which will explore in more detail various clinical and epidemiological aspects of the material. Further data currently is being collected through the field liaison network on reported cases, and this information will be included in the discussion of the final report.

Implications

Several clinical and epidemiological implications can be drawn from this survey material at this stage of analysis. The large number of benign tumors reported suggests that clinicians should be alert to possible liver pathology in young women on oral contraceptives presenting with even vague and non-specific abdominal symptoms. Consideration should be given to any liver pathology before oral contraceptives are prescribed. Careful follow-up of oral contraceptive users with a history of liver pathology is indicated.

This American College of Surgeons survey already has stimulated some hospitals to include all primary liver tumors in their registries, and it is recommended that this practice be adopted by all registries in hospitals with approved cancer programs.

Another problem highlighted by the survey material and recognized by clinicians is confusion of nomenclature and classification of these benign liver neoplasias. The American College of Surgeons has pursued these difficulties by requesting slides of tumors reported in the initial survey, and designating a group of pathologists to carry out an independent review of the histologic diagnosis with a view toward clarifying terminology.

Considering the widespread use of oral contraceptive methods in the United States and throughout the world, an urgent need exists for collaborative, controlled, retrospective studies to ascertain quickly the risk of primary liver tumors in users of oral contraceptives and to study the relevance of factors such as duration and pattern of use of oral contraceptives, age at start of use, synthetic estrogen taken, and previous liver disease.

The survey report forms requested information on type of oral contraceptive used and length of time taken, but these data were not always available. Oral contraceptives usually contain a synthetic progestogen and a synthetic estrogen in varying dosages. Various progestogens are prescribed, but only two synthetic estrogens are in use: ethinyl estradiol and mestranol. Mestranol is demethylated in the liver to ethinyl estradiol. Fifty-four tumors occurred in women on the synthetic estrogen mestranol, 18 in women on ethinyl estradiol, and 61 in women who did not know the type of oral contraceptives they were taking or who were on other estrogen therapy. Proportionately more women in the "unknown" group had malignant tumors.

The finding of far more tumors among mestranol users concurs with the findings in a controlled study by Edmondson and colleagues, who compared 68 women on oral contraceptives, 34 with benign liver tumors and 34 liver-disease-free controls. In Edmondson's material, all the women with benign liver tumors were taking mestranol, while half the control cases were using ethinyl estradiol.

In the present study, analysis of length of usage by synthetic estrogen showed no differences. Analysis of frequency of tumors by progestogen used was also inclusive.

However, the first oral contraceptives on the market contained mestranol exclusively. Ethinyl estradiol was first introduced as an oral contraceptive in 1964, and marketing figures for oral contraceptive prescriptions indicate that until 1970 mestranol was used more frequently than ethinyl estradiol by the general population. Therefore, the fact that more women with tumors were observed to be taking mestranol may reflect in very large part the greater availability for a longer period of time of this preparation.

Update on Metropolitan Emergency Medical Services (MEMS)

J. NORMAN BERRY, M.D., *Atlanta**

Since July 1, 1976, Metropolitan Emergency Medical Services (MEMS) has been operational, providing a single seven-digit telephone number (231-2323) for medical emergencies throughout the Atlanta toll-free call area. MEMS utilizes a sophisticated computer-aided dispatch system which automatically identifies the *nearest appropriate* ambulance. A specially designed telecommunications system then allows the MEMS medical communicator to transfer the call to the appropriate dispatcher.

A redundant computer system automatically identifies the three nearest ambulances, shows the street map coordinates and estimated time of arrival of each, and identifies each as an advanced or basic life support unit. The MEMS communicator then selects the appropriate unit (or two if an ALS unit is required but is more than six minutes away) and pushes a button to transfer the video information to the ambulance dispatcher. The dispatcher immediately sees on his terminal screen the information obtained from the caller, and dispatches the ambulance.

The metro Atlanta public, once faced with an array of over 2,000 telephone numbers for medical assistance, have quickly responded to the MEMS number and have supported efforts to upgrade the quality of EMS throughout the region. After eight months of operation, MEMS now receives approximately 250 calls daily. The average time for MEMS to interrogate a caller, enter information into the computer terminal, select a unit, and transfer the call to a dispatcher is now approximately 30 seconds and decreasing toward the goal of 20 seconds (most police originated calls are transferred in 10 seconds).

In addition to providing a single telephone number for metro area residents, MEMS receives all local operator-dialed calls for medical emergencies, and similarly transfers these calls to the nearest ambulance provider. The metro area has a unique resource—the largest toll-free call area in the world, covering parts of 17 counties and including some 650,000 telephones. Before July, if a local citizen dialed the operator for a medical emergency, he may have reached an operator in Jonesboro, Lawrenceville, or Columbus, Georgia, depending on how busy the lines were. Since July 1, all operator-dialed calls in the 17-county area have been referred to MEMS instead of a distant operator (who may never have visited Atlanta and would not likely know who to call for the nearest ambulance).

The availability of community-wide prehospital emergency cardiac care can significantly reduce the death and disability rates of coronary disease. During a three-year period of advanced emergency cardiac care in Seattle, Washington,[1] coronary death in ambulances fell by 75%, prehospital coronary death by 26%,

* President, MEMS Board of Directors. Dr. Berry's address is 6500 Vernon Woods Dr., NE, Atlanta, Ga. 30328.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, care of the Georgia Heart Association, Broadview Plaza Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

and community coronary death by 15% in persons aged 30 to 69 years. Of those promptly resuscitated, prehospital, 60% survived longterm, and 13.4 lives per 100,000 people aged 30 to 69 years were saved yearly. The 8.8% hospital mortality for acute myocardial infarction and 5% frequency of cardiogenic shock of patients managed prehospital were remarkably lower than patients hospitalized by other means. The Atlanta Regional Commission has estimated the MEMS single number will save approximately 400 lives each year in the metro area.

In addition to providing a single number for medical emergencies, MEMS has provided three complete sets of CPR training equipment to train area residents in CPR. The importance of CPR in saving heart attack victims was demonstrated in a recent study by Lund and Skulberg,[2] indicating that promptness rather than professional expertise matters most in salvaging a heart attack victim. In a study of 631 patients admitted to hospitals after cardiac arrest, 75 of the patients received resuscitation promptly by lay people before admission to the hospital. The survival rate of this group was 36% as contrasted with only 8% in the 556 patients who were left to wait for the ambulance crew. An effective CPR training program directed toward the public can reduce delay in initiating resuscitation, thereby reducing mortality and morbidity.

MEMS is currently supported by 15 cents per capita from Cobb, Douglas, and Rockdale Counties. Fulton County, which has supported MEMS since the early planning stages, is currently reviewing its support of the MEMS program. MEMS and the Fulton County Commission recently agreed on the following principles during a site visit by the Commission to the MEMS Center:

1) There should be a single telephone number for medical emergencies in Fulton County;

2) The nearest appropriate ambulance should respond to any emergency regardless of location of the call, even though a government subsidy may be required for indigent calls;

3) Fulton County should have greater input into the MEMS program.

The MEMS Board of Directors has requested each participating county government (Cobb, Douglas, Fulton and Rockdale) to designate a Commissioner or other representative to serve on the MEMS Board. Representatives of Fulton County and MEMS will meet during April, 1977, to further discuss these and other issues related to coordinated emergency medical services.

For additional information, the interested reader may refer to "An EMS System for Metropolitan Atlanta."[3]

REFERENCES

1. Crampton, R. S. et al.: "Amelioration of Prehospital and Ambulance Death Rates from Coronary Artery Disease by Prehospital Emergency Cardiac Care," *Journal of the American College of Emergency Physicians,* January-February, 1975.

2. Lund, I. and Skulberg, A.: "Cardiopulmonary Resuscitation by Lay People," *Lancet* 2:702-704, 1976.

3. Berry, J. Norman. *J.M.A. Georgia* 64:94-95, 1975.

ADVANCED LIFE SUPPORT INSTRUCTOR COURSE SCHEDULED MAY 13-15, 1977

The Georgia Heart Association will present an Advanced Cardiac Life Support (ACLS) Instructor Course for Physicians on Friday through Sunday, May 13-15 in Atlanta.

Ambrose G. Hampton, Jr., M.D., a member of the American Heart Association's National ACLS Faculty, will be the National Faculty member for the course. He is in the private practice of cardiology in Columbia, S.C.

Robert F. Finegan, M.D., chief of staff at South Fulton Hospital in East Point, is course director. He is a member of the American Heart Association's Affiliate Faculty in ACLS and serves on the Georgia Heart Association's CPR (cardiopulmonary resuscitation) Task Force.

The course is designed for cardiologists, emergency room physicians, anesthesiologists and other physicians actively engaged in the area of advanced cardiac life support. It is a standard course which was developed by the American Heart Association as directed by the National Academy of Sciences-National Research Council.

Those who successfully complete the course will be certified as instructors.

Registration is limited to 48 physicians.

For more information, contact the Georgia Heart Association, 2581 Piedmont Road, N.E., Atlanta, GA 30324.

Federal Health Maintenance Organization Amendments of 1976

SCOTT KILLINGSWORTH, *Atlanta**

Between the idea and the reality . . . falls the shadow.
—T. S. Eliot

CONGRESS IS NO MORE immune than the rest of us to the vagaries of the passage from idea to reality. The Health Maintenance Organization Act of 1973[1] (the "original Act") was enacted for the purpose of making "available to all Americans a real choice with respect to the form of medical delivery they individually wish to purchase"[2] by fostering the development of Health Maintenance Organizations ("HMOs") throughout the nation. Two years and $26.3 million in grants and loans later, only five HMOs had become federally qualified.[3] This failure of the HMO idea, as expressed in the original Act, to capture the imagination of the private sector propelled Congress in 1976 to enact a package of amendments[4] designed to bring the idea of federally-assisted HMOs into greater congruence with economic and political reality.

An HMO provides a wide range of medical services to a defined, enrolled population for a predetermined, prepaid premium. The premium is normally unrelated to the quantity of care received by any particular member. In most cases, care is furnished either at a central location by a staff of HMO-employed physicians or by a medical group, or at diverse locations by physician members of an individual practice association ("IPA") affiliated with an HMO. A number of benefits are said to flow from this organizational form, particularly when delivery of care is centralized. Since an HMO must assume the risk of providing services to all its members out of a fixed premium income, and since the HMO must compete economically with indemnity plans, there is a strong incentive to economize. HMO proponents feel that centralized HMOs can accomplish this goal through elimination of duplicate equipment and facilities, increased use of paraprofessionals, emphasis on preventive care, and, most significantly, reduction of unnecessary procedures and hospitalization. Moreover, centralization is said to improve the quality of care by assuring continuity and accessibility and by facilitating referral to and consultation with appropriate specialists. From the viewpoint of the physician, the Senate Committee on Labor and Public Welfare has concluded that HMO affiliation reduces the cost of medical practice, increases professional support from colleagues, stabilizes work schedules, and diminishes the financial risk of entering practice.[5]

While a number of studies have tended to confirm that HMO members use significantly less hospital and surgical care than matched non-enrolled populations,[6] the extent to which the other anticipated benefits materialize in the HMO context remains subject to debate[7] or, in some cases, largely unexamined.[8] The

---

* Prepared at the request of the Medical Association of Georgia. Mr. Killingsworth is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

original Act was intended in part to create a "field laboratory" in which these claims could be evaluated.

The original Act has two major parts: the first defines the requirements for federal qualification; the second confers benefits upon qualified HMOs. Direct financial benefits include grants, contracts and loans for feasibility surveys and initial development and operation costs. A substantial marketing benefit is conferred by a "dual-choice" provision that requires employers with twenty-five or more employees living in an area served by a qualified HMO to offer HMO membership to those employees as an alternative to any indemnity plan made available by the employer. Following passage of the original Act, the emerging pattern of underutilization of these striking financial and marketing advantages suggested a need for fundamental changes elsewhere in the Act. Some of the more material changes brought about by the 1976 amendments are discussed below.

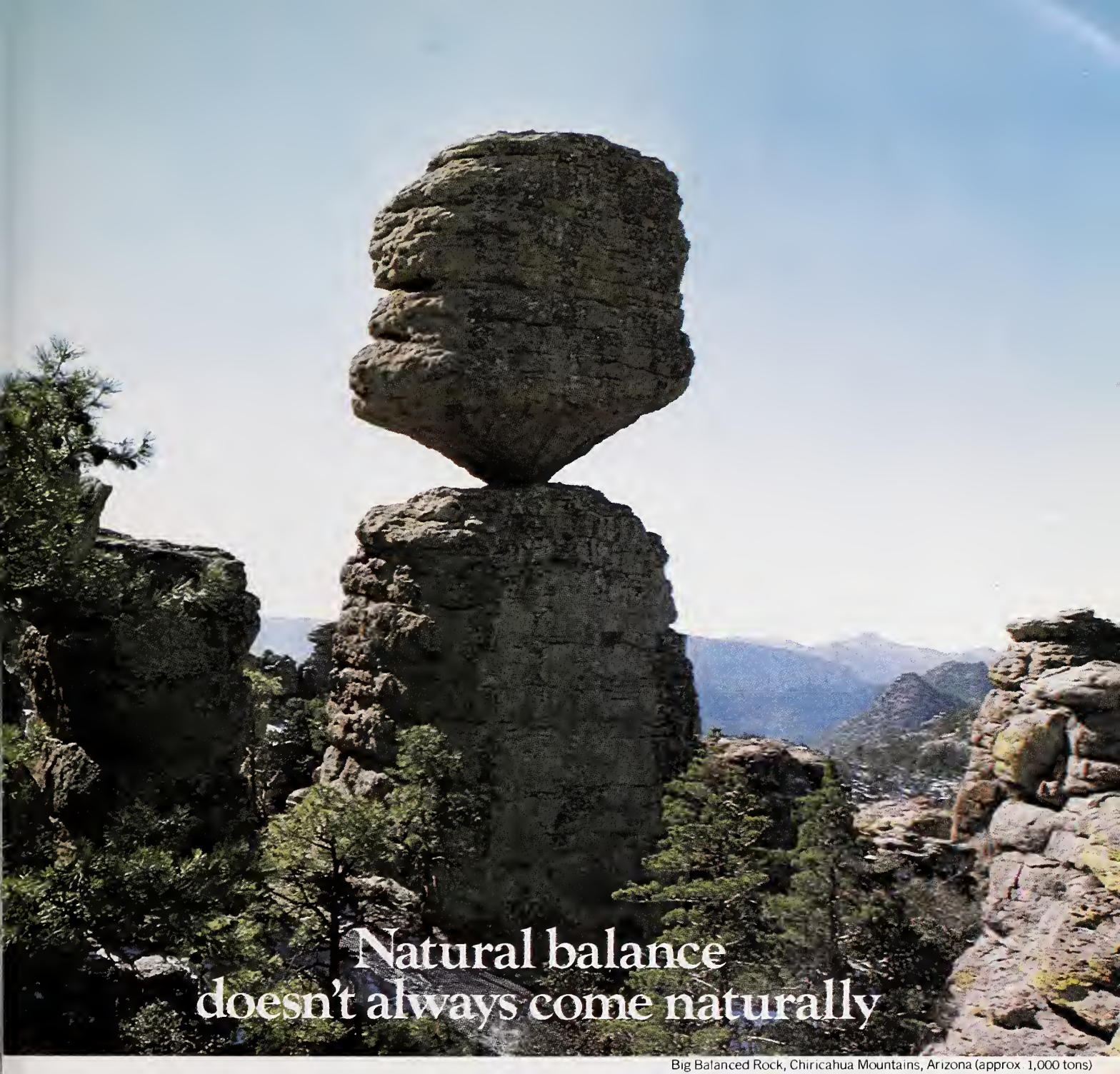
Problems With the Original Act

Administratively, the HMO program suffered from sluggishness in the publication of regulations and an inadequate level of technical assistance to applicants. Without the benefit of guidelines defining their obligations under the original Act, embryonic HMOs hesitated to apply for aid. These difficulties were largely attributed to the dispersal of the 125 persons assigned to the HMO staff of HEW among twenty-one different HEW offices, each run by a different director.[9] The amended Act clarifies the intent of Congress that the program be administered through a single identifiable unit of HEW.

More fundamental problems lay in the criteria for qualification. What began as an open-ended HMO concept designed to foster structural experimentation had by 1973 become a rigid and demanding set of requirements, largely due to the influence of lawmakers who wanted HMOs to be comprehensive health care systems tailored for integration with a national health insurance program.

The original Act required each HMO to furnish certain "basic health services" to all its members, and prohibited an HMO from requiring members to purchase any additional services. The latter prohibition prevented experimentation with more inclusive basic packages and also conflicted with certain state HMO laws which prescribed broader basic coverage than the federal law. The original Act also required each HMO to make available (for an extra premium) a number of "supplemental health services," such as long-term care and extraordinary vision, dental and mental care, whether or not any member actually contracted for them. The amended Act still requires that an HMO provide all the "basic health services," but allows an HMO to include additional services in its basic package, and to make available only those supplemental services which members actually contract for. In addition, "basic health services" has been redefined to exclude preventive dental care for children (a prohibitively expensive service) and to include immunizations, check-ups for adults, well-child care and children's ear examinations, which the typical HMO can more easily provide.

The original Act required medical services to be furnished through either the HMO staff, a medical group, or an IPA, with narrow exceptions for infrequently used services. Any medical group associated with an HMO was required to practice for the HMO as its principal professional activity. Under the amended Act, an HMO may use any combination of staff, medical groups, and IPAs, and may also contract with individual physicians or groups which do not qualify as medical groups or IPAs, so long as such contracts do not consume a total of more than thirty percent of the dollar value of all physician services provided through the HMO. The resultant opportunity for self-determination should enable HMOs to adapt more readily to the peculiar needs of their members and to the unique features of the surrounding medical community (for example, the availability of a cancer center), while retaining the assurance that routine medical services will be performed by a stable core of physicians. A medical group no longer must practice principally for its affiliated HMO; the amended Act requires only that the



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25

(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

group have "substantial responsibility" for the provision of services to an HMO, and even this more reasonable standard does not apply until the HMO has been qualified for three years. Hence a medical group can now minimize its financial exposure by "testing the water" for three years instead of choosing either to jump in feet first or to stay out altogether.

A Major Amendment

While the foregoing changes primarily enhance the structural flexibility of HMOs, another goes directly to the issue of financial survival: the "open enrollment" amendment. Originally, the Act required HMOs to hold open enrollment periods of at least thirty days annually, during which individuals were to be accepted for membership without reference to their health status, unless an HMO could prove that compliance would jeopardize its economic viability. This competitive disadvantage compared with insurers proved unacceptable to many potential HMOs, particularly in view of the difficulty of proving economic jeopardy before the fact. The strong reaction to this provision convinced Congress to subordinate the goal of coverage for everyone to that of widespread establishment of HMOs. The amended Act defers the open enrollment requirement until the HMO either has been in operation for five years or has 50,000 members, and limits the number of applicants required to be accepted in any one year to three percent of the previous year's net increase in enrollment. The amendments also permit an HMO, during the open enrollment period, to refuse to enroll chronically institutionalized applicants.

The open enrollment amendments cast an interesting light on the dissension within Congress as to the real purpose of the Act. While the majority apparently held that stimulation of HMO development should be paramount, even if this required some concessions to those who were supposed to form HMOs, others did not agree. In a minority report on the open enrollment admendment,[10] three Senators[11] concluded that the objection of the medical community to the original provision "raises serious questions in our mind about the motivation and ability of the private sector to deal with pressing and important social needs . . . if the private sector is incapable of adequately dealing with the health care needs of the American people, ever-increasing Federal intervention will be inevitable." They went on to propose that, if open enrollment placed HMOs at a competitive disadvantage compared to conventional insurers, the preferred solution would be to impose the open enrollment requirement on the entire health insurance industry.

While these Senators view the HMO concept as a mere steppingstone to national health insurance, the majority appears to think of it as a possible alternative to such a program, with final judgment on the issue reserved until there exists a sufficient number of different types of HMOs to permit systematic study. Equally important, the majority seems to have concluded that the private sector can accomplish a great deal, but only if it is provided a reasonable incentive to do so. Whether adequate incentive now exists is a question time alone will answer.

NOTES

1. Public Law 93-222, December 29, 1973.
2. Senate Report No. 93-129, April 27, 1973.
3. House Report No. 94-518, September 26, 1975.
4. The Health Maintenance Organization Amendments of 1976, P.L. 94-460, October 8, 1976.
5. Senate Report No. 93-129.
6. Cf. Gaus, Cooper and Hirschman, "Contrasts in HMO and Fee-For-Service-Performance," Office of Research and Statistics, Social Security Administration, 1975 and sources cited therein.
7. For example, the Gaus study disclosed no significant difference between HMO and fee-for-service patients in the use of non-physician health personnel, number of physician visits, or satisfaction with care. The amount of preventive care received by fee-for-service patients actually exceeded that of HMO enrollees.
8. Apparently little has been done to evaluate HMOs from the viewpoint of the HMO-employed physician.
9. Senate Report No. 94-844, May 13, 1976.
10. Contained in Senate Report 94-844.
11. Kennedy, Hathaway and Nelson.

Brown, Bruce B., Muscogee—I&R
P.O. Box 951, Columbus 31902

Cabot, William, Cobb—Act—Oph
3903 S. Cobb Dr., Smyrna 30080

Calhoun, Charles L., Muscogee—Act—Oph
1929 8th Ave., Columbus 31901

Campbell, Earl Roy, Jr., Walker-Catoosa-Dade—Act—Or
525 McCallie Ave., Chattanooga 37402

Carden, H. Lamar, Muscogee—I&R
P.O. Box 951, Columbus 31902

Chao, Yu-Chia, Franklin-Hart—Act—FP
350 Church St., Royston 30662

Coan, Mark G., DeKalb—Act—Su
4536 Chamblee-Dunwoody Rd., Atlanta 30341

Devaney, James O., Muscogee—I&R
P.O. Box 951, Columbus 31902

Diaz, Santiago V., Baldwin—Act—Or
750 N. Cobb, Box 714, Milledgeville 31061

Fang, Kuo-Kang, Sumter—Act—I
1301-A E. Forsyth St., Americus 31709

Feliciano, E. A., MAA—Act—I
490 Peachtree St., NE, Atlanta 30308

Fineberg, Edward M., Richmond—Act—Oph
Talmadge Memorial Hospital, Augusta 30902

Finlayson, Donald C., MAA—Act—Anes
Emory University Hospital, Atlanta 30322

Fisk, John R., MAA—Act—Or
Emory University Clinic, Atlanta 30322

Golden, Robert M., Cobb—Act—I
2550 Windy Hill Rd., Suite 309, Marietta 30062

Goodale, Fairfield, Richmond—Act—Path
1120 15th St., Augusta 30901

Guthre, Troy H., Jr., Richmond—Act—I
Route 2, Box 252-J-20, Hephzibah 30815

Harrison, Gary N., Richmond—I&R—I
Medical College of Ga., Box 1085, Augusta 30902

Holmes, Hamilton E., MAA—Act—Or
Emory University Clinic, Atlanta 30322

Horne, Kenneth W., CWL—Act—R
1010 Prince Ave., Athens 30601

Johnson, Robert W., Richmond—Act—Su
1430 Harper St., Augusta 30902

King, Stephen H., MAA—S—PH
Public Health Service, 50 7th St., Atlanta 30325

Light, Gerald S., S. Ga.—Act—Pd
107 Woodrow Wilson, Valdosta 30601

Lykins, Lawrence E., Richmond—I&R—U
Medical College of Ga., Augusta 30902

Maholick, Leonard T., MAA—Act—P
2905 Peachtree Rd., NE, Atlanta 30305

Marks, Richard E., Muscogee—S—N
Martin Army Hospital, Ft. Benning 31905

Merritt, Bradley S., SW Ga.—Act—I
208 N. Cuthbert, Colquitt 31737

Molinaro, John R., Richmond—Act—GE
1467 Harper St., Suite 501, Augusta 30902

Moss, Stephen H., MAA—A—Or
Ga. Baptist Hospital, Box 529, Atlanta 30312

Naidu, Sarveswar I., Richmond—Act—Or
Medical College of Georgia, Augusta 30902

Northington, James W., Muscogee—S—Su
Martin Army Hospital, Box 566, Ft. Benning 31905

Rodriquez, Antonio R., Richmond—Act—I
Medical College of Ga., Augusta 30902

Smith, Arthur M., Richmond—Act—U
Medical College of Ga., Augusta 30902

Smith, James L., CWL—Act—ObG
740 Prince Ave., Athens 30601

Swartz, Fredric A., Richmond—Act—Su
3623 Dewey Gray Cir., Suite 113, Augusta 30904

Torres, William E., DeKalb—Act—R
Emory University Hospital, Atlanta 30322

Vargo, James D., DeKalb—Act—P
Emory University Clinic, Atlanta 30322

SOCIETIES

The **DeKalb County Medical Society** has published a directory to help DeKalb citizens become familiar with the many health resources available to them.

Called the Health Services Directory, the brochure is divided into two parts. The first, a Service Index, lists the various agencies and organizations that provide particular services. The second section, a Resource Index, lists the addresses and telephone numbers of each of the agencies. The society printed 50,000 copies of the directory and gives a copy to anyone who either

stops by the office or sends in a self-addressed stamped envelope.

PERSONALS

First District

John Mooney, M.D., was honord as the 1976 "Man of the Year" by the Statesboro Rotary Club. Currently Director of Willingway Hospital, Dr. Mooney has worked extensively in the areas of alcoholism and drug dependency and is nationally active in teaching and lecturing on the subject.

Metter pediatrician **Robert B. Gottschalk** has been elected Chief of Staff of Candler County Hospital. Other officers elected were **J. Dorsey Smith, M.D.,** vice president and **Robert L. Pence, M.D.,** secretary.

Third District

Americus physician **J. G. Herron** was elected president of the Middle-Flint Diabetes Association, an organization formed a year ago to help diabetics and their families become better informed about diabetes, to promote an awareness among the general public of the magnitude of diabetes and to promote research.

Fourth District

The 1976 Julius McCurdy Citizenship Award was presented to **O. Wytch Stubbs Jr., M.D.** for his work as volunteer Medical Director of the Scottdale Medical Clinic. The award is given annually in recognition of a medical doctor in DeKalb County who has made outstanding contributions to his community.

Seventh District

Joel Todino, M.D., Chief of Medicine at Redmond Park Hospital and Chairman of the Floyd County Heart Unit, writes a medical column every other weekend for the *Rome News-Tribune*. Dr. Todino's column touches on items of interest to the general public in the field of medicine.

DEATHS

Leonard H. Campbell

Leonard H. Campbell, M.D., 56, died March 2 in the Medical Center of Central Georgia, following a long illness. Dr. Campbell had been Bibb County Medical Examiner for the past 20 years. Before assuming his duties as Medical Examiner, he served three years as the Chief Pathologist for the Macon Hospital (now the Medical Center of Central Georgia).

He was graduated from the University of Arkansas Medical School in 1944 and later studied as a fellow in pathology at the Benning Institute at the University of Toronto.

A native of New Edinburg, Arkansas, he had lived and practiced pathology in Macon since 1954.

Survivors include his wife, Doris; a daughter and son, both of San Francisco, California; four sisters.

Herman Douglas Jones

Founder of the Georgia Crime Laboratory, Herman Douglas Jones, Ph.D., died March 6 at the age of 78. Dr. Jones, an honorary member of the Medical Association of Georgia, began his career teaching biochemistry at Alabama Polytechnic Institute (now Auburn University). While there, he helped start the first statewide crime lab in the country.

After coming to Atlanta, Dr. Jones taught at Oglethorpe University before starting the Fulton County Crime Laboratory in 1947. When the state took over the lab in 1952, he continued as its director until his retirement in 1972.

Survivors include his wife, two sons, a sister and a brother.

Robert B. Nuttall

Robert B. Nuttall, M.D., died in February at the age of 52. He had been practicing medicine in Austell for the past 15 years.

Born in Elizabeth, New Jersey, Dr. Nuttall received his M.D. from George Washington University Medical School and served his internship at St. Elizabeth Hospital, Washington, D.C. He was Chief of Staff of the Holy Family Hospital in Atlanta from 1968-70.

A member of the Professional Advisory Board of the Childbirth Education Association, he was preparing a discussion program for the group at the time of his death.

Survivors include his wife, Ella Benson Nuttall; daughter, Mrs. Carlyn Gwyn Moser; sons, Robert A., Harry, Nathan and Paul; his mother; a brother.

Edmund Joseph Virusky

Baxley surgeon Edmund Joseph Virusky died February 25 at the age 62, following a short illness.

A native of Freeland, Pennsylvania, Dr. Virusky was a graduate of the University of Maryland School of Medicine and served his internship at St. Francis Hospital in Pittsburgh, Pennsylvania.

The veteran of World War II had lived in Baxley for 26 years, serving as surgeon for the Southern Railway System and the Georgia Power Company's Plant Hatch. He was also Chief of Staff of the Appling General Hospital.

Survivors include his wife, Mrs. E. J. Virusky; a daughter, Mrs. W. G. Floyd; a son, Major Edmund Joseph Virusky Jr.; three grandchildren.

Certification Exam For Physician's Assistants

The National Commission on Certification of Physician's Assistants has scheduled the 1977 Certifying Examination for Assistants to the Primary Care Physician for October 5, 6, 7, and 8. The deadline for receipt of applications is July 6, 1977.

Formal training programs will receive an ample supply of applications for their students directly from NCCPA.

For eligibility information and/or individual applications, write:

Registrar, NCCPA
Suite 560, 3384 Peachtree Rd., NE
Atlanta, Ga. 30326
Telephone: (404) 261-1261

physicians:

we treat you seriously in the air force...

As an Air Force officer, you'll practice in a highly professional atmosphere, supported by a team of highly qualified technical assistants. You'll treat patients in your specialty in new and modern health care facilities. You'll enjoy the finest specialty training in military and civilian hospitals. The Air Force has many opportunities for unlimited professional development, with a carefully individualized plan to make the best use of your skills, knowledge, and ambition. From research to the finest in clinical medicine, our centers offer a full range of available openings. For a full-time career without the time-consuming burdens of private practice, a minimum of administrative detail, and a maximum of leisure time, consider our offer . . .

Write Today for More Information:

Capt. Lohman D. Reiter
Suite 208, 3050 Presidential Dr.
Atlanta, Ga. 30340
Or Call Collect: (404) 451-3888

R3 find your perfect practice in the air force
4

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

Carter Attacks Health Costs

The Carter Administration has fired the first torpedo in its opening battle against escalating health care costs by asking Congress to approve a "permanent hospital cost containment system" that would cover all hospital operations, private as well as governmental.

Recommended in the revised budget prepared by the Administration is a limit of about nine percent on increases in reimbursement for operating costs per admission for each hospital for the fiscal year that starts Oct. 1.

Other features of the plan "to contain the continued rapid and disturbing rise in the cost of health care" included:

- waiver for states with acceptable hospital rate review programs.
- separate controls on hospital outpatient departments, to encourage alternatives to inpatient care.
- federal programs to encourage additional cost containment activities such as second opinion before surgery, pre-admission review for non-emergency hospital care, etc.
- monitoring for federal compliance, primarily using data already reported by hospitals for other programs, such as Medicare and Medicaid. Hospitals found in violation of reimbursement ceilings in any year could "repay" excesses by reducing charges or reimbursement increases in future years. Civil and criminal penalties would be included to combat fraud and abuse.

Under the proposal, the Health Education and Welfare Department Secretary would appoint a National Advisory Committee "of broad representation" to help determine future trends in spending for hospital care.

The program would be directed by the Health, Education and Welfare Department and would begin with a directive from Congress to establish limits on annual rates of increase in hospital reimbursement from all payors, beginning in fiscal year 1978, after consultation with the health industry and the public. The program itself would be administered in large part by the hospitals and private third party payors, according to HEW.

The plan is to evolve a more permanent cost containment program later. This plan would remain in effect "until absorbed by reimbursement provisions of a comprehensive national health insurance plan."

Savings of such a program were estimated to be about $1 billion the first year, rising to $5.5 billion in 1981.

The cost containment plan, which hasn't been fully worked out yet, will be submitted to Congress shortly for legislative approval following meetings with such interested outside organizations as the American Hospital Association, the American Medical Association and Blue Cross, HEW Secretary Joseph Califano told reporters at the HEW budget briefing. Other organizations notified to meet with HEW included the Health Insurance Association of America and the Federation of American Hospitals.

Despite the sweeping scope of the proposal, covering private expenditures as well as those under federal programs, Califano denied the plan represented a return to the wage-price freeze system of several years ago. He insisted the new plan was a different animal.

Asked why physician fees were not covered, the HEW Secretary said his department is taking "one step at a time." Califano said "we will be looking at that to see what should be done." There has not been enough time to move in this area with a proposal that could work and that would be fair to the people involved, he said.

The hospital cap is no cinch to clear Congress which has been leery in recent years of wage-price freeze plans and which last year refused even to consider President Ford's recommendation for caps on Medicare reimbursement increases for physicians and hospitals. A key factor could be the position of organized labor which is vigorously opposed to federal wage-price restraints. In addition, health care lawmakers have been considering their own proposals to curb the costs of Medicare-Medicaid including a prospective reimbursement plan for hospitals.

A ceiling on hospital cost increases is "an essential prerequisite to a future national health insurance program," said Califano . . . "The cost containment program represents the first step in making national health insurance financially feasible."

Under the plan, no hospital could increase its overall level of charges by more than the negotiated and federally sanctioned ceiling.

Califano said that if hospitals raise charges without economic justification before the program goes into effect "it may be necessary for the legislation to have sufficiently retroactive impact to nullify the benefits of such improper conduct."

John Alexander McMahon, President of the American Hospital Association, immediately declared that any program that sets an arbitrary limit on one segment of the economy while ignoring the rest is "inequitable, unworkable and may well be counterproductive."

Asserting the flat opposition of the AHA to the proposal, McMahon said a cost containment plan must take into account wage and price increases beyond the control of hospitals as well as the individual circumstances of each institution.

Recent statistics show that food and fuel prices are rising faster than those for health care, according to the AHA President. "Hospital charges have gone up as a direct response to the public's need for access to quality health care," he said.

The Federation of American Hospitals called the plan "unrealistic and unfair." John A. Bradley, FAH President said, "The goal is laudable, but legislation imposing controls on prices without controls on wages and supplies is unrealistic and unfair. The proposal is a retread of President Nixon's Phase IV control program and it is

inconsistent with President Carter's policy against wage-price controls, as well as his desire to reduce the growth of government."

Bradley said an arbitrary cap on reimbursement "would be a government directive to hospitals to sacrifice the quality of care."

He added: "It is disappointing that government has not addressed the causes of hospital inflation, particularly the malpractice problem. Under an arbitrary cap, a hospital could find itself in the ludicrous position of having to restrict the number of tests a physician may order."

Military Medical School

The Carter Administration has announced plans to write off the military medical school as a $50-million mistake.

Defense Secretary Harold Brown said: "The University of Health Sciences is to be closed, its current students placed elsewhere in scholarship programs and its facilities put to other use. Physician needs of the military services can be satisfied more economically over the long run by direct recruitment. The 1978 budget can be reduced by $14 million."

The surprise decision came as the military medical school was midway through its first year of operation with 32 students and construction of a building was well along on the grounds of the Bethesda Naval Medical Center near Washington, D.C.

The school has been opposed by the American Medical Association since Congress considered the proposal in 1972. In the interim it also has come under severe attack from various study commissions and lawmakers as an inordinately expensive method of producing relatively few physicians for the armed services.

Congress may move to reverse the Administration's decision, although the prime mover for the school—former Rep. F. Edward Hebert (D-La.), Chairman of the House Armed Services Committee—is no longer in Congress. There is strong backing for the school on both committees, but it has not been tested to date by a forceful presidential move to kill the facility.

The defense announcement was part of a series of policy proposals contained in President Carter's revised budget for fiscal 1978.

Price Put on NHI

The dilemma facing the Carter Administration on national health insurance was bluntly stated by the Congressional Budget Office in its annual report. A plan fully financed by taxes, as Labor proposes, would use most of the money available for new programs "and would most likely require compensating reductions in other federal programs or tax increases above current policy levels." The budget office, which helps guide and determine Congress' spending and legislative plans, put the 1982 cost of such an NHI plan at a minimum of $108 billion.

Alice Rivlin, Director of the Budget Office which functions in relation to Congress much as the Office of Management and Budget functions in relation to the Executive branch, said a strong economy could leave room for new federal programs adding up to an additional $50 billion of spending a year over the next several years. However, a wholly tax-financed NHI plan would swallow this and more, if no cost-sharing devices were featured such a plan—as urged by organized Labor—"could add from $168 billion to $200 billion to federal health expenditure by fiscal year 1982," said the Budget Office report. In contrast, the report continued, "a compulsory employment-based, premium-financed plan with cost-sharing (such as the AMA proposal) might increase federal spending by as little as $15 to $20 billion in 1982."

New VA Head

President Carter has nominated a Vietnam war veteran, Max Cleland, 34, to head the Veterans Administration. Cleland lost two legs and an arm from a grenade explosion in battle. In 1971 be became the youngest member of the Georgia Legislature.

The appointment was seen as a victory for the younger Vietnam veterans groups who have urged one of their own be appointed. Cleland ran unsuccessfully for Lieutenant Governor of Georgia in 1974 and then joined the staff of the U.S. Senate Veterans Affairs Committee.

Physician Extenders Encouraged

The government is moving on two fronts to encourage the use of physician extenders (PE's) in rural areas.

The Social Security Administration has launched an experimental program to reimburse physicians for "independent" medical services provided Medicare beneficiaries by physician extenders. Previous policy had been to reimburse physicians for PE Medicare Part B services only those "incident to" a physician's services and performed under the direct supervision of the physician. The new policy will permit payment for the independent services of physician's assistants, nurse practitioners, medex and similar non-physician health care providers. The reimbursement will be made only to a physician extender's employer, not to the PE directly.

The new Social Security policy was announced shortly before Congress opened hearings on legislation with strong backing in House and Senate to require Medicare reimbursement for qualified PE programs in rural areas without the restriction of direct physician supervision. Although the four major bills up for consideration do not call for direct payment to PE's, they differ in reimbursement policies with some allowing reimbursement to rural clinics and others requiring that reimbursement be channeled only through the responsible physician.

Knotty medical, ethical and policy questions will be aired at the hearings by the House Ways and Means Subcommittee on Health, with the issue of professional liability heading the list. On an even broader front, the lawmakers must consider limitations on what services can be provided by the PE's without stepping into the province of physicians. The amount of supervision and responsibility resting on the physician for the services of PE's will be a key issue. The reimbursement procedure is involved in all of these questions.

Practices that wish to be considered for enrollment in the experiment, or wish to receive further information regarding the experiment, should call collect to the University of Southern California, Division of Research in Medical Education, (Social Security contractor) at 213/221-2147 from 9:00 a.m. through 4:00 p.m., California time. All such queries must be made by May 1, 1977.

The government noted there are more than 7,000 formally trained PE's. "Whether this manpower re-

source continues to grow, or even continues to exist, depends in part up on federal reimbursement policies. The effect of such policy can only be magnified by the introduction of national health insurance."

Waiver on FMG Restrictions

The State and Justice Departments, heeding the plight of hard-pressed hospitals, have agreed to a one-year waiver of new restrictions on admissions of "exchange visitor" foreign medical graduates. The waiver was requested by the HEW Department. Congress had signalled its agreement with the relaxation of requirements in the health manpower bill approved last year.

Hospitals had complained that the new restrictions, if implemented, would have slashed staffs of hospitals dependent on FMGs. The law's requirement that residence in this country is limited to two years with a third year on approval was not waived. Since more than half of FMG residents are on immigrant status rather than exchange visitors, hospitals fear FMG staffs will be depleted anyway.

The American Hospital Association, the American Medical Association and many other medical groups had argued against the law's clamps on FMGs, contending that hardships would result and that the increasing supply of domestic physicians over time would end hospital reliance on FMGs.

Sen. Edward Kennedy (D-Mass.), who was instrumental in securing passage for the controversial restrictions on FMGs, and Rep. Paul Rogers (D-Fla.), Chairman of the House Commerce Health Subcommittee, have written a joint letter to the State and Justice Departments urging the government next year to submit a plan for eventual phasing-out of "ill-trained" foreign physicians.

WHERE YOUR TAX MONEY GOES

Social welfare expenditures under public programs increased to $331 billion in fiscal 1976. This was a one-year dollar increase of almost $45 billion, the second largest in history and a rate of increase of 15.7% over 1975 spending. These figures were reported by the Social Security Administration's Office of Research and Statistics.

Even after allowing for inflation, the 1976 social welfare expenditures rose in constant dollars by 8.3% in 1976.

Cash transfer payments to individuals under all types of income-maintenance programs were $22.5 billion higher in 1976 than in 1975. Social Security accounted for $8.9 billion of this increase, unemployment insurance for $5.6 billion, and public assistance and supplemental security income for $1.9 billion. In the health field, Medicare expenditures rose by $3 billion and Medicaid by $2.3 billion.

An important factor in this increase, according to the U.S. Department of HEW, has been the growing role of the federal government in providing health services. Through 1965, when Medicare was enacted, it was financing less than half the public bill for health; by 1976, the federal share was more than two-thirds.

The rise in federal spending for social welfare is reflected in its relationship with total federal spending. In 1950, the federal government devoted 26% of its budget to social welfare. This figure reached 33% by 1965 and 56% in 1976.

MEDICAL CAREERS

M.D.s
Hospital Administrators
Nursing Home Administrators
Comptrollers
Department Heads
Office Managers
Medical Social Workers
L.P.N.s
Master Social Workers
A.S.C.P.
Directors of Nursing
Physicians' Associates
R.R.A.
X-Ray Technicians
Medical Assistants
Medical Secretaries
A.R.T.
Medical Sales

ALL MEDICAL & PARAMEDICAL

O'KEEFE PERSONNEL SERVICES

3384 Peachtree Road, N.E.
(404) 266-1153

Eager and Simpson

Since 1919

- ☐ Hospital Fittings of Orthopedic Supports
- ☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

Got a knack for public speaking? Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at **(404) 876-7535; INWATS (800) 282-0224.**

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

WEIGHT WATCHERS

2639 North Decatur Road
Decatur, Georgia 30033

For class information in the Atlanta area call: 373-5731
Outside the Atlanta area dial free: 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1976-1977

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

20/150 H

20/100 EAR

20/70 ING IS

20/50 AS PRECIOUS

20/40 AS SIGHT HAV

20/30 YOU HAD YOUR HE

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP

250
230
210
190
170
150
130
Lidov

When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study[1] Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate[2]

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Zaroxolyn®

(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:
1. Dornfeld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* **18**: 527-533, 1975.
2. Data on file, Medical Department, Pennwalt Prescription Products.

PENNWALT
Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Medical Meeting Calendar

APRIL

27-30—*St. Simons Island;* **SECOND ANNUAL ST. SIMONS ISLAND SYMPOSIUM ON LUNG DISEASE;** Category 1 Credit; Contact: Gilbert D. Grossman, MD, Emory School of Medicine or Georgia Lung Assoc, 1383 Spring St., NW, Atlanta 30309.

28-30—*Atlanta;* **POST GRADUATE SEMINAR ON GYNECOLOGIC ONCOLOGY AND COLPOSCOPY COURSE;** Category 1 Credit Pending; Contact: Ernest W. Franklin, III, MD, 25 Prescott St., NE, Atlanta 30308.

28-30—*Louisville;* **DIAGNOSIS AND MANAGEMENT OF THE HIGH RISK PREGNANCY;** Category 1 Credit; Contact: Office of Continuing Education, University of Louisville School of Medicine, Louisville, KY 40201.

28-May 1—*Callaway Gardens;* **ANNUAL MEETING OF THE GEORGIA SOCIETY OF DERMATOLOGY;** Contact: Stewart Wiegand, MD, 6500 Vernon Woods Dr., NE, Atlanta 30328.

MAY

1-5—*Atlanta;* **MEETING OF SOCIETY OF TEACHERS OF FAMILY MEDICINE;** Contact: Gary Kahn, MD, National Medical Audiovisual Center, Center for Disease Control, Atlanta.

2-4—*Atlanta;* **1977 SOUTHEAST EMERGENCY MEDICINE CONGRESS;** Category 1 Credit; Contact: Medical College of Georgia, Div. of Continuing Education, Augusta 30902.

3—*Ft. Oglethorpe;* Program in **CARDIOLOGY;** Category 1 Credit; Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hosp. Ft. Oglethorpe, GA 30742.

6-7—*Point Clear, AL;* **REGIONAL MEETING OF AMERICAN COLLEGE OF PHYSICIANS;** Category 1 Credit; Contact: Thomas N. James, MD, Dept. of Medicine, University of Ala Medical Center, Birmingham, AL 35294.

8-11—*Chicago;* **MEETING OF AMERICAN ASSOCIATION OF PLASTIC SURGEONS;** Category 1 Credit; Contact: M. J. Jurkiewicz, MD, Div. of Plastic Surgery, Emory University Hosp, 1364 Clifton Rd., Atlanta 30322.

8-12—*Orlando, FL;* **MEETING OF AMERICAN SOCIETY OF COLON AND RECTAL SURGEONS;** Category 1 Credit; Contact: Ms. H. Gibson, 320 W. Lafayette, Detroit, MI.

8-12—*Atlanta;* **INTERNATIONAL CONFERENCE ON PSYCHONEUROENDOCRINOLOGY;** Category 1 Credit; Contact: Richard P. Michael, MD, Dept. of Psychiatry, Emory School of Medicine, Atlanta 30322.

9-11—*Atlanta;* **THE RECOGNI- AND MANAGEMENT OF CONDITIONS THAT PRODUCE CHEST "PAIN";** Category 1 Credit, Contact: Assoc. Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta 30303, Tel: (404) 659-1676.

9-11—*Atlanta;* **THE RECOGNITION AND MANAGEMENT OF CORONARY ATHEROSCLEROTIC HEART DISEASE AND OTHER CONDITIONS THAT PRODUCE CHEST "PAIN";** Category 1 Credit; Contact: Miss Mary Anne McInery, Div. of Continuing Education, American Col. of Cardiology, 9650 Rockville Pk., Bethesda, MD 20014.

9-12—*Chicago;* **AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS ANNUAL CLINICAL MEETING;** Category 1 Credit; Contact: ACOG Resource Center, Amer. College of Obstetricians and Gynecologists, One East Wacker Dr., Chicago 60601.

12-13—*Atlanta;* **CURRENT CONCEPTS IN ELECTRODIAGNOSIS;** Category 1 Credit; Contact: Emory University, Center for Rehabilitation Medicine, 1441 Clifton Rd, NE, Atlanta 30322.

15-17—*Memphis;* **GENERAL SPORTS MEDICINE;** Category 1 Credit; Contact: Amer. Academy of Orthopaedic Surgeons, Box 6310-A, Chicago, IL 60680.

18-20—*Lexington, KY;* **SYMPOSIUM ON RADIOLOGY OF THE NON-TRAUMATIZED EMERGENCY ROOM PATIENT;** Category 1 Credit; Contact: Frank R. Lemon, MD, Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

25-27—*Atlanta;* **CLINICAL TOPICS IN GYNECOLOGY & OBSTETRICS;** Category 1 Credit; Contact: Assoc. Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta 30303, Tel: (404) 659-1676.

26-27—*Lexington;* **PEDIATRIC CHEST PROBLEMS;** Category 1 Credit; Contact: Frank R. Lemon, MD, Continuing Education, College of Medicine, Univ. of Kentucky, Lexington, KY 40506.

29-June 11—*Miami;* **REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE;** Category 1 Credit; Contact: Jose Bocles, MD, Dept. of Medicine, University of Miami School of Medicine. P.O. Box 520875, Miami 33152.

JUNE

1-3—*Lexington;* **INTERNATIONAL CONFERENCE ON THE CLINICAL USES OF CARCINOEMBRYONIC ANTIGEN (CEA);** Category 1 Credit; Contact: Frank R. Lemon, MD, Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

9-10—*Atlanta;* **FIRST ANNUAL CONFERENCE ON PAIN: "HOW TO MEASURE PAIN";** Category 1 Credit; Contact: Steven F. Brena, MD, Anesthesiology and Rehabilitation Medicine, Emory Univ. School of Medicine, Pain Control Center, Emory University Clinic, Atlanta 30322.

9-11—*Jekyll Island;* **SELECTED TOPICS IN INTERNAL MEDICINE;** Category 1 Credit; Contact: Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

13-15—*Buford;* **FERTILITY CONTROL: WHERE ARE WE NOW: WHERE ARE WE GOING?** Category 1 Credit; Contact: Assoc. Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta 30303.

20-July 3—*Switzerland, Italy & France;* **ALPS-RIVIERA MEDICAL SEMINAR,** Category 2 Credit; Contact: Medical Assoc. of Atlanta, 875 W. Peachtree St., NE, Atlanta 30309.

18-22—*San Francisco;* **126th ANNUAL CONVENTION OF THE AMERICAN MEDICAL ASSOCIATION;** Category 1 Credit; Contact: AMA, 535 N. Dearborn St., Chicago, IL 60610.

20-24—*Miami;* **MEETING OF AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY;** Category 1 Credit; Contact: Ms. M. H. Henry, 38238 Glenn Ave., Willoughby, OH 44094.

23-25—*Hilton Head, SC;* **CURRENT STATUS AND CONTROVERSIES IN PACEMAKERS;** Category 1 Credit; Contact: Dale E. Braddy, Director of Continuing Education, Amer. College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.
Professional Liability—Umbrella—Property

YOUR Insurance AGENT

A unique hospital specializing in treatment of...

ALCOHOLISM
DRUG ADDICTION



In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

EXPERIENCED PHYSICIAN (GP or any specialty) needed for large Atlanta corporation 10-15 hours/week to assist with medical administration such as review of sick claims and occasionally contacting doctors by phone. Reply Box 4-1.

INTERNIST to provide medical services to Atlanta corporate medical department 5-10 hours/week. Reply Box 4-2.

CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialities included. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

FAMILY PHYSICIAN OR GENERAL INTERNIST wanted to join two-man well-established family practice group. Primarily adult practice, no O.B. Pleasant community of 50,000, modern 225 bed hospital, excellent benefits. May inquire through William L. McDaniel, Jr., M.D. or Robert W. Simmons, M.D., 1203 Memorial Drive, Dalton, Georgia 30720, Telephone: 404-278-0138.

GOING PRACTICE, General M.D. Owner is ill and wants one or two doctors to take over practice and lease building. Already-equipped, beautiful old two-story house in downtown Atlanta near major hospitals. Contact Sam Sanders, Northside Realty Associates, Inc. Telephone: 252-3900; 993-4311.

PHYSICIAN'S ASSISTANT in Anesthesia/Life Support Systems seeks practice with anesthesiology group. Trained in anesthetic techniques, monitoring and critical care techniques, including respiratory care. For resume, contact: Michael Gilliland, 1170 Briarcliff Court #6, Atlanta, Ga. 30306.

FOR RENT—CALLAWAY GARDENS, GEORGIA. Pine Mountain Club Chalet 55, Beautiful redwood chalet on Lake Innsbruck. 3 bedrooms, 2 baths, sleeps 10 comfortably, central AC, dishwasher, completely furnished, large deck, grill. Quiet. Walk to tennis, swimming, fishing; 3-minute drive 63 holes Callaway Golf. $30 daily, $195 weekly. James Z. Shanks, M.D., Atlanta, Reservations 404-663-2211.

Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.

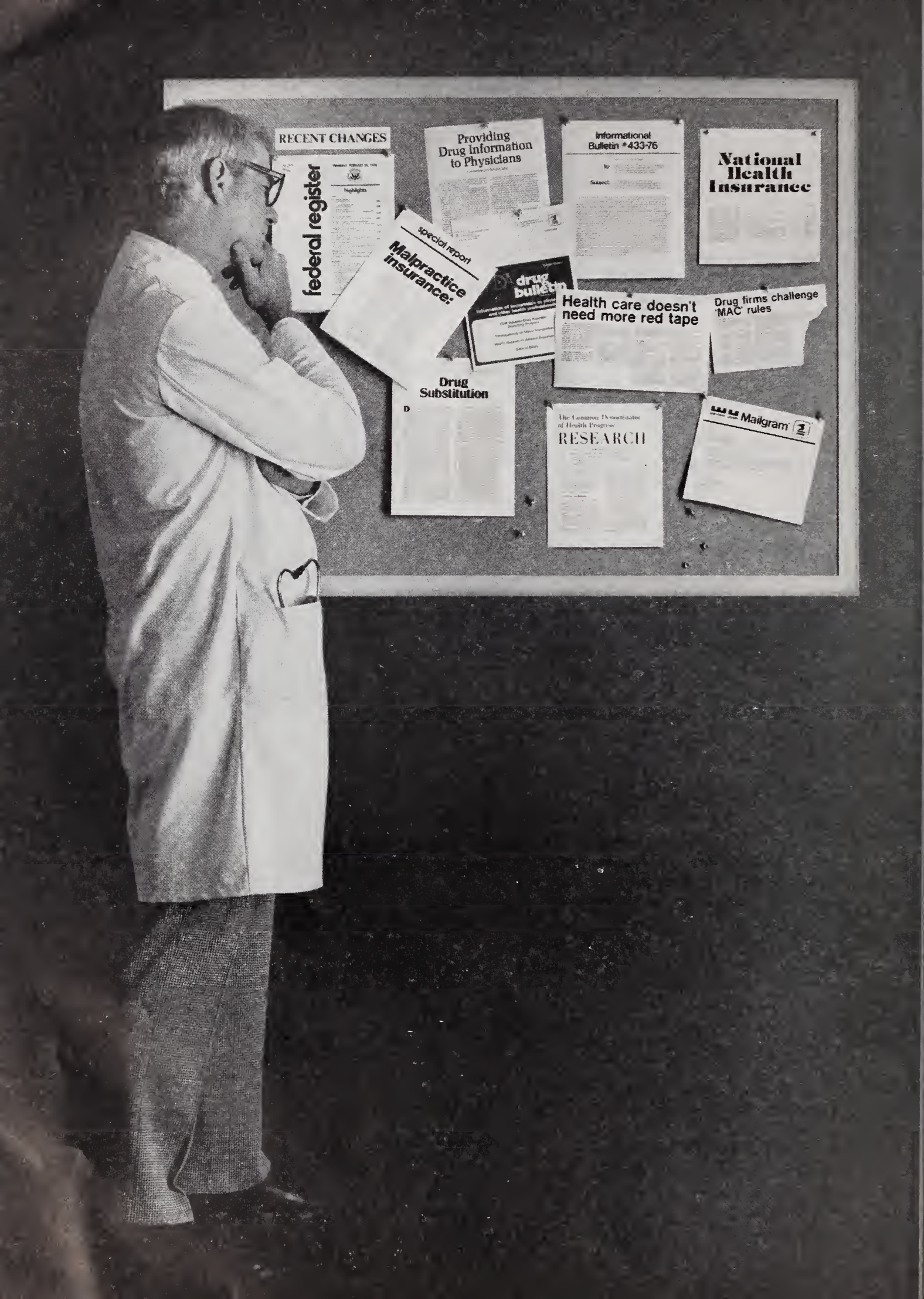
Armour Pharmaceutical Company
Greyhound Tower
111 West Clarendon Avenue
Phoenix, Arizona 85077

☐ Send latest information on Paget's Disease of Bone.
☐ Have your representative call on me.

Dr. _____

Address _____

City _____ State _____ Zip _____


RECENT CHANGES
federal register
highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
To:
Subject:
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
D
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

MAG SERVICES INCORPORATED

QUALITY
AND
INEXPENSIVE

PRINTING SERVICES FOR DOCTORS

PRESCRIPTION BLANKS
Standard Size 4¼ x 5½ in Pads of 100

500	1000	2000	4000
5.75	7.95	14.65	26.55

BUSINESS CARDS OR APPOINTMENT CARDS

	1000	2000	4000
White Stock One Side	6.95	12.65	22.95
For Color Stock, Add	1.00	2.00	4.00
For Two Sides	11.85	20.95	39.95

LETTERHEADS

20 LB. WHITE BOND				
SIZE	**500**	**1000**	**2000**	**4000**
7¼ x 10½ 8½ x 11	11.16	15.70	24.98	42.72
20 LB. RAG CONTENT (25%)				
7¼ x 10½ 8½ x 11	13.90	21.16	35.91	64.75

ENVELOPES
TO MATCH LETTERHEADS

24 LB. WHITE WOVE				
SIZE	**500**	**1000**	**2000**	**4000**
6¾	12.88	15.96	25.51	47.90
Monarch	13.70	17.59	28.76	54.40
#10	13.77	17.74	29.06	55.00
20 LB. RAG CONTENT				
Monarch	20.23	30.63	54.86	106.60
#10	20.86	33.97	57.43	111.75

WINDOW ENVELOPES
24 LB.

SIZE	500	1000	2000	4000
6¾	13.83	17.84	29.26	55.40
#10	14.85	19.89	33.36	63.60

Composition and type set charges are in addition to quoted prices.

UNIFORM INSURANCE CLAIM FORMS (Approved by AMA)
$18.50/1000 — Single Copies — Pads of 100

SEND ORDERS TO:
MAG SERVICES, INC.
(a service company of the Medical Association of Georgia)
968 PEACHTREE ST., N.E.
ATLANTA, GA. 30309
(404) 873-4136

ATTENTION PHYSICIANS

If you are interested in joining a major Primary Care Group Practice in Houston or Dallas . . . the I*MED Program is the answer.

I*MED, INC. is currently constructing five Primary Care Clinics in Houston and Dallas with exceptional Physician opportunities . . .

*Guaranteed Base Salary

*Percent of Revenue

*Paid Professional Liability Insurance

*No Overhead

*Shared Call

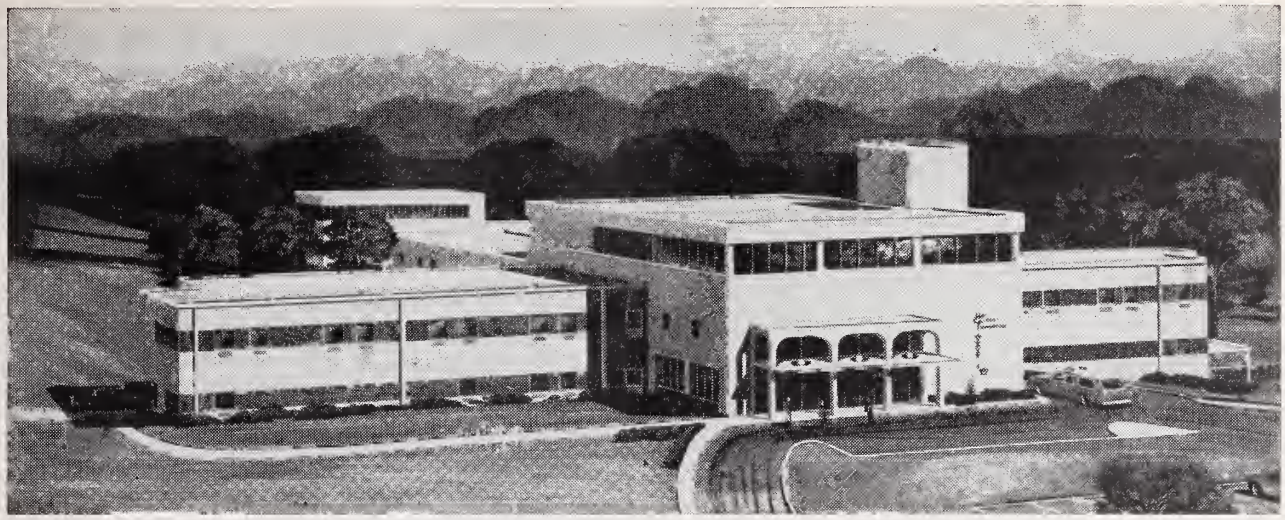
*Peer Group Practice
. . . and more

Interested Physicians Contact:

Stephen C. Smith

I*MED, INC.

10910 Katy Road
Houston, Texas 77043
(713) 932-1111



HILL CREST HOSPITAL

FOR INTENSIVE TREATMENT OF PSYCHIATRIC DISORDERS

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR:
Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

THE LIBRARY
OF CALIFORNIA

Index to Advertising

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

Vol. 66 April 1977 No. 4

Armour Pharmaceutical Company 255
Walter Ballard Optical Company 254
Beltone Electronics Corporation 249
Brawner Hospital, Inc. 206
Burroughs Wellcome Co. 214
Classified Advertising 255
Dickey-Mangham Company 248
Eager and Simpson 247
Georgia Cancer Line 232
Georgia Society of CPAs 215
Hill Crest Hospital 259
I Med, Inc. 258
Eli Lilly and Company 216
MAG Services 258
Metropolitan Psychiatric Center 210, 211
O'Keefe Personnel Services 247
Parke, Davis and Company 212
Peachtree and Parkwood Hospitals 209
Penwalt Prescription Products 250, 251
Pharmaceutical Manufacturers Association 256, 257
Potter-Holden & Company 254
Practice Productivity, Inc. 208
Roche Laboratories 204, 261, 262
Roerig 239
Sherwood's Commercial Broker 208
Smith, Kline & French 240
United States Air Force 244
United States Navy 208
The Upjohn Company 252
Valley Psychiatric Hospital 248
Warner Chilcott 213
Weight Watchers of Greater Atlanta 248
Willingway Hospital 254
Workman-Brown, Inc. 205

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.**, 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Libr
has been the object of ongoing pharmacologic and clinical investigatic

The published record on Librium is enormous. So large, in fact
put it into a computer literature retrieval system to make it more accessi
in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ℞
chlordiazepoxide HCl/Roche



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

JOURNAL
of the medical association of
georgia
MAY / 1977

WHAT PRICE HEALTH ?

Physician
Page 288

Cost Containment
Special Issue

Government
Page 302

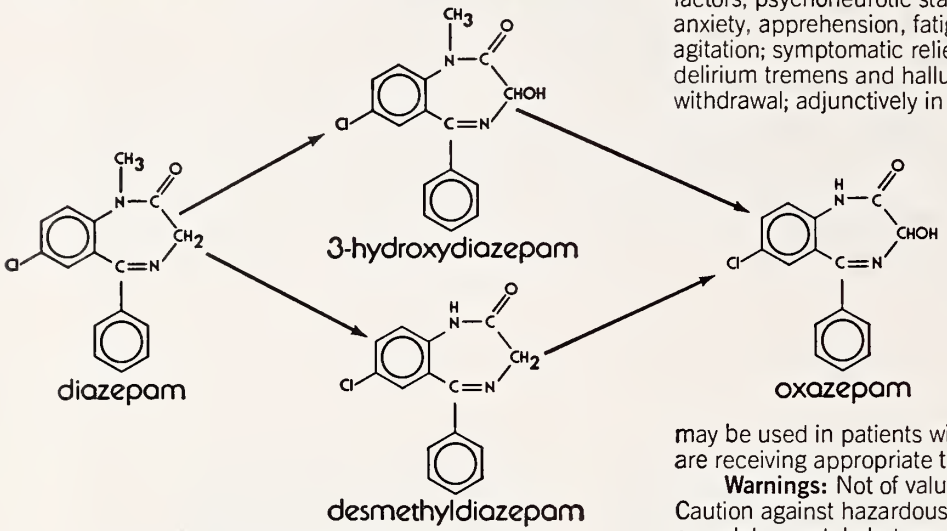
MAG Committee
Page 282

Insurance
Page 291

Hospital
Page 298

LIBRARY
U.C. SAN FRANCISCO
JUN 1 1977

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Preferred Partnerships inc.



RE: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Mr;

How much income tax are you now paying? We can help you shelter a portion of your present income---plus show you how you can receive Tax-Free income.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that give you a 4-to-1 or better write-off. We have investments in the $5,000 - $8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

BRAWNER HOSPITAL, INC.

Established 1910

3180 ATLANTA STREET, S.E.
SMYRNA, GEORGIA 30080
Telephone 404 436-0081



Located in the metropolitan Atlanta area, this psychiatric hospital is staffed by the members of the Center for Interpersonal Studies, P.A. Emphasis is placed on individual and group psychotherapy on an intensive basis. Each patient is assigned a staff psychiatrist who is responsible for the planning of an individualized treatment program, coordination of the assets of the therapeutic community and a continuing liaison with the patient's family and referring physician.

A comprehensive range of services is provided. There are facilities for evaluation and intensive treatment of patients with emotional problems which can be managed in an open psychiatric facility. An accredited high school is located on the hospital grounds and efforts are made to coordinate work with the local school system.

Member of the American Hospital Association and the National Association of Private Psychiatric Hospitals.

Accredited by the Joint Commission on Accreditation of Hospitals.

Mark A. Gould, M.D.
Medical Director

William H. Benson, M.D.
Psychosomatic Medicine

Ronald C. Bloodworth, M.D.
Psychiatry

Herbert Gorod, M.D.
Psychiatry

Karl S. Mihalovits, M.D.
Clinical Director

Jesse R. Peel, M.D.
Psychiatry

Harry Porter, Jr., M.D.
Psychiatry

Frederick W. Huff, Ph.D.
Psychology

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 5

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

277 Transient Ischemic Attacks: Is Medical Therapy Efficacious?
Richard R. Whitlock, M.D.
Kay F. McFarland, M.D.
Albert A. Carr, M.D.

SPECIAL ARTICLES

282 Report from MAG's Committee on Cost Accountability
The Members of the Committee
288 Cost Containment—At All Costs!
Harrison L. Rogers Jr., M.D.
291 Health Care Costs—Quo Vadis?
Fred R. Higginbotham
298 The Anatomy of Hospital Costs
W. Daniel Barker, F.A.C.H.A.
302 Wake Up, Doc!
Douglass M. Richard

EDITORIALS

312 Responsible Restraint: A Key to Cost Control
Edgar Woody Jr., M.D.
313 High Blood Pressure Month: Treatment Is the Theme
Joseph A. Wilber, M.D.

FEATURES

304 I've Told This Before/Those Impish Little Devils
J. G. McDaniel, M.D.
315 President's Letter/Quality Care Comes First
Robert E. Perry Jr., M.D.
316 Letters to the Editor
319 Cancer Page/Summary Statement from Workshop on Late Effects of Irradiation to the Head and Neck in Infancy and Childhood
323 Heart Page/Vasodilators: an Advance in Management of Congestive Heart Failure
Arthur J. Merrill Jr., M.D.
328 Legal Page/So You Want to Counterclaim
Daryll Love

THE ASSOCIATION

331 New Members
331 Societies
332 Personals

NEWS

301 FAH on Carter Hospital Control Plan
301 Milton Friedman on Government Involvement in Health Care
314 Impaired Physicians Conference
322 Certification Exam for Physician's Assistants
337 The Month in Washington
341 Medical Meeting Calendar

THE COVER

Most of this issue is dedicated to a most timely and important topic: Health Costs. The issue features input from physicians, a hospital administrator, the president of Blue Cross and Blue Shield of Georgia/Atlanta and a government official. They each give specific recommendations as to how health costs can be contained. Add comments by MAG President Robert Perry (page 315) and Editor Edgar Woody (page 312) and you have a goldmine of ideas—food for thought and blueprints for action. Cover design by Bob Hamill, Atlanta.

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.
Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Hill Crest
HOSPITAL
Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.
Phone: 205-836-7201

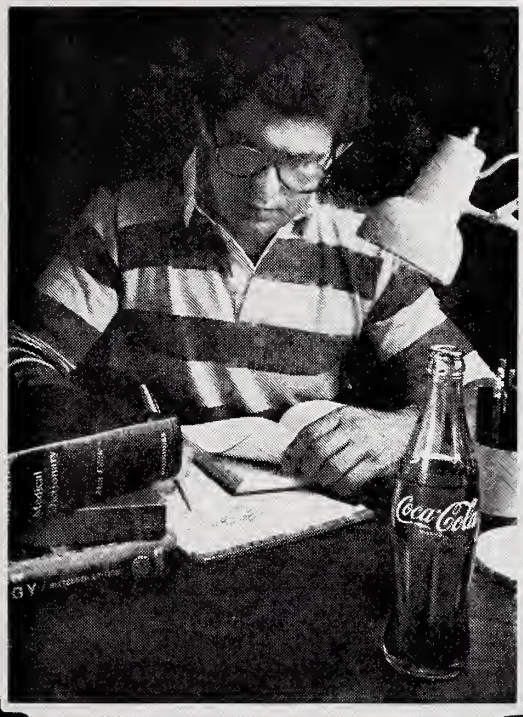


A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

Coke adds life to... those special moments.



June 2: 2 A.M. Me! Cramming for Inorganic Chemistry finals. Man was I beat!



Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

'Coca-Cola' and 'Coke' are registered trade-marks which identify the same product of The Coca-Cola Company.

PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200





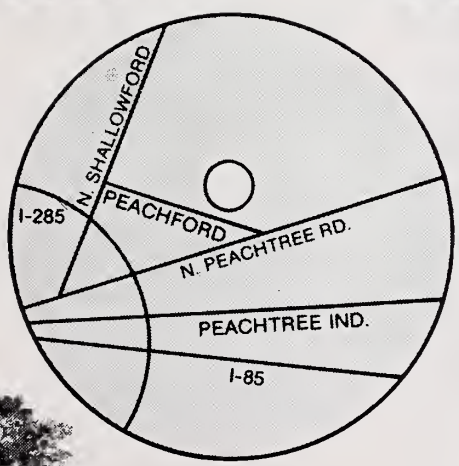


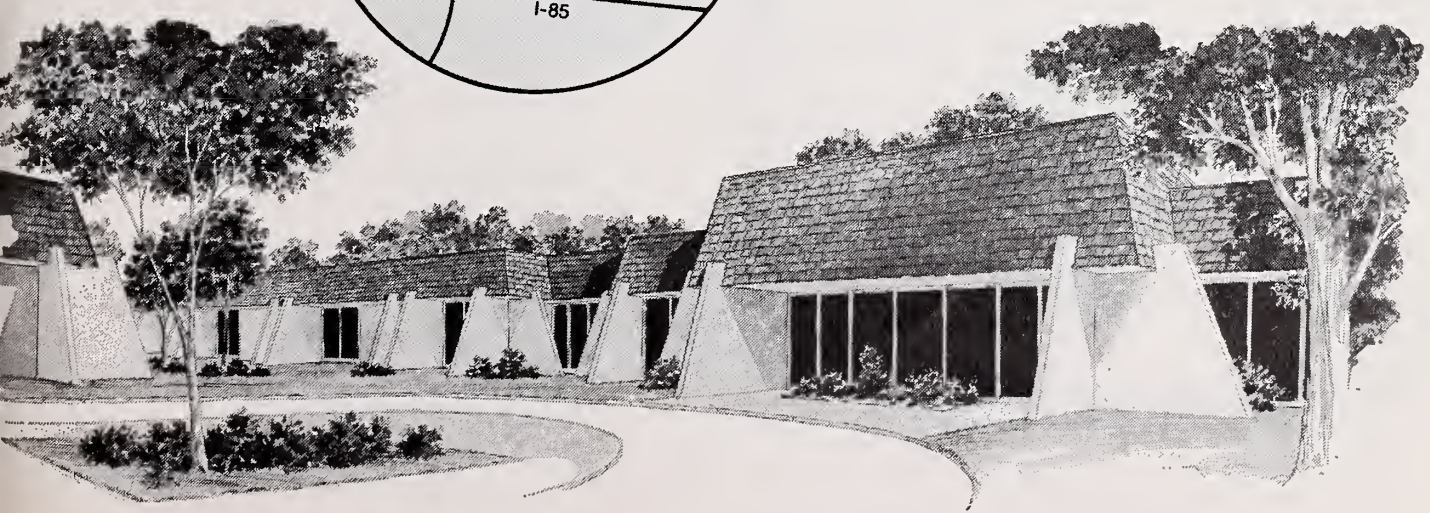






PEACHFORD PERSONNEL PICTURED





ATTENTION PHYSICIANS

If you are interested in joining a major Primary Care Group Practice in Houston or Dallas . . . the I*MED Program is the answer.

I*MED, INC. is currently constructing five Primary Care Clinics in Houston and Dallas with exceptional Physician opportunities . . .

*Guaranteed Base Salary

*Percent of Revenue

*Paid Professional Liability Insurance

*No Overhead

*Shared Call

*Peer Group Practice
. . . and more

Interested Physicians Contact:

Stephen C. Smith

I*MED, INC.

10910 Katy Road
Houston, Texas 77043
(713) 932-1111

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



When you're good people recognize you.

Highly effective
Single-dose convenience
Non-staining
Economical
Pleasant tasting

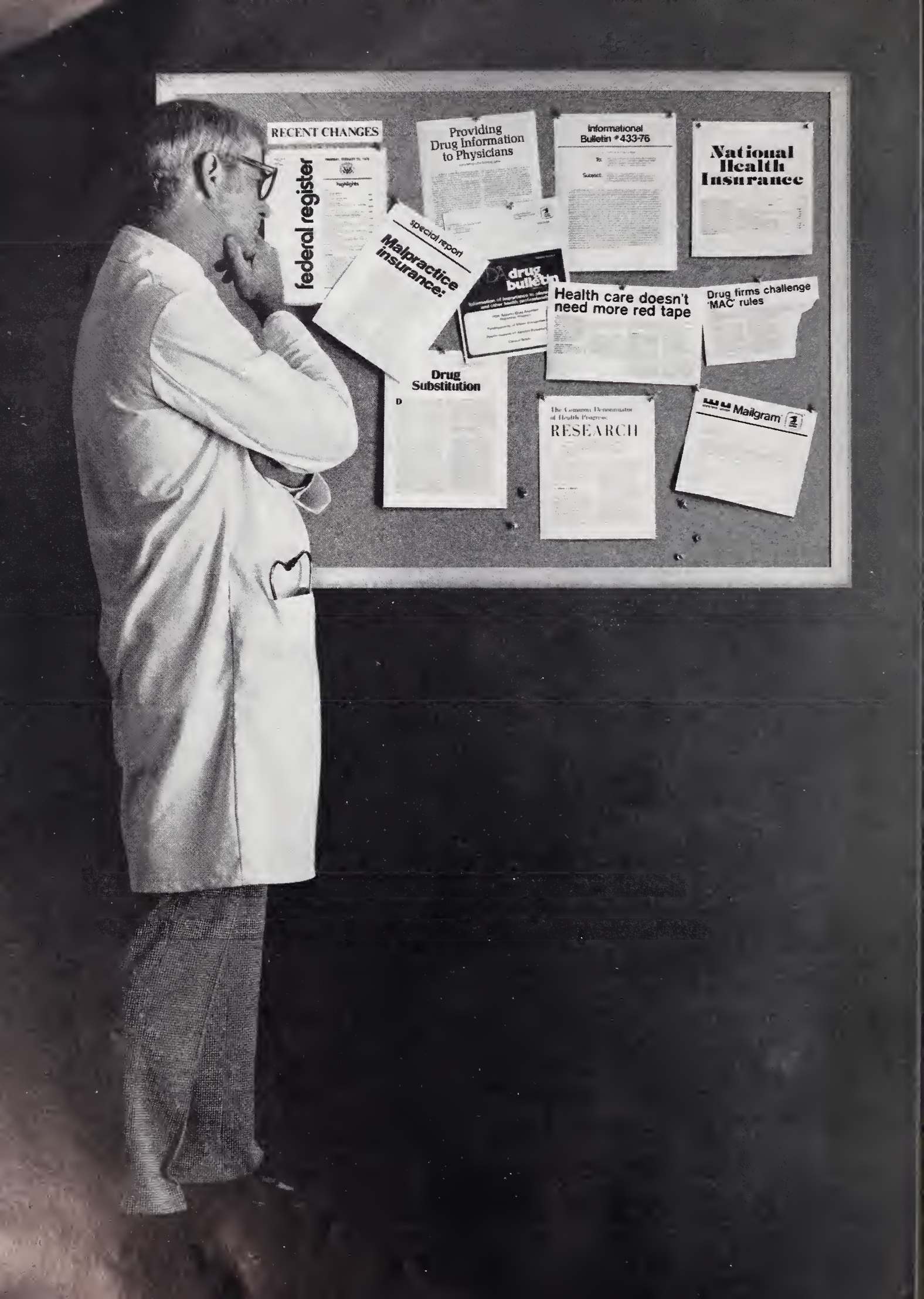
Antiminth®
(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION

a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

©1977 LONE RANGER T.V., INC.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

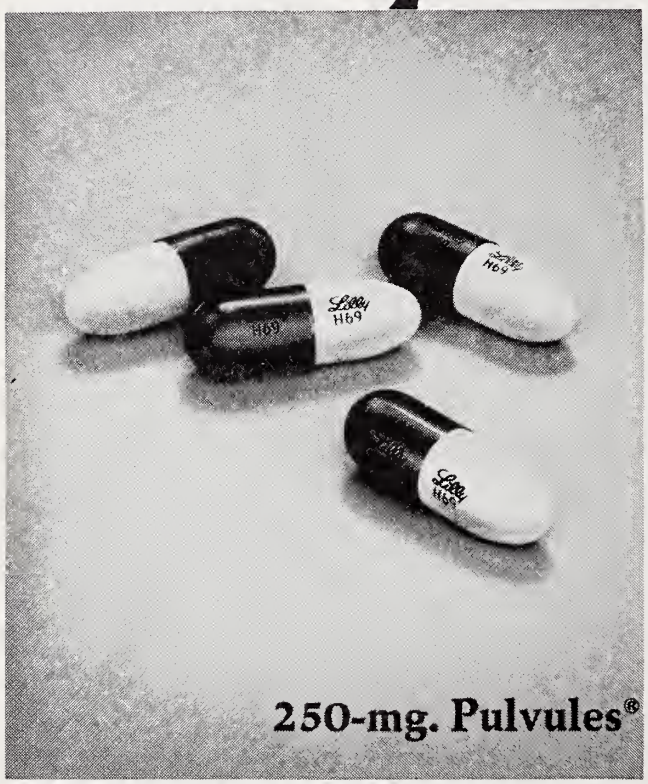
If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

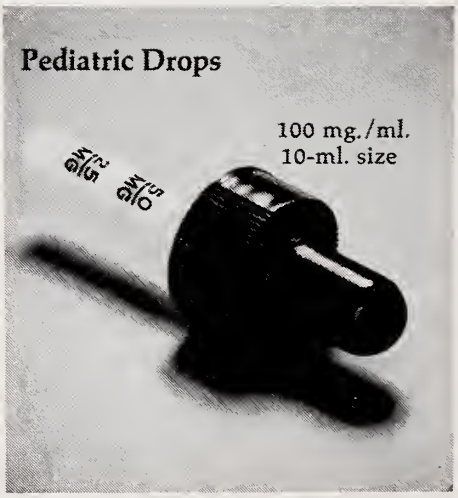


Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

easy to take







Keflex®
cephalexin

Lilly

500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

JOURNAL
of the medical association of
georgia

Transient Ischemic Attacks: Is Medical Therapy Efficacious?

RICHARD R. WHITLOCK, M.D., KAY F. MCFARLAND, M.D. *and*
ALBERT A. CARR, M.D., *Augusta**

TRANSIENT ISCHEMIC ATTACKS (TIAs) have been defined as episodes of reversible, focal neurological deficit. The spells are of abrupt onset and persist for less than 24 hours. The treatment of transient ischemic attacks has remained controversial despite several studies in the past two decades. Coumadin derivatives, aspirin, and surgical correction of extracranial lesions have been the principal modes of therapy. Unanswered questions remain concerning the therapeutic benefits versus complications of surgical and medical therapy, and the role of aspirin as compared to coumadin in the treatment of TIAs.

Available data on history and therapy of TIAs is discussed

Designing and performing a study to answer these questions would be difficult for one group of investigators, because of the large number of patients which must be treated in order to obtain significant results. A cooperative, prospective study is needed, for it would avoid the inconsistencies in baseline data and provide uniform definitions and criteria for judging the efficacy of different therapeutic regimens which cannot be obtained by pooling data from studies done during the past 20 years. The purpose of this review is to summarize and assess the data which is now available that pertains to the natural history and medical therapy of transient ischemic attacks.

In June 1975, Cervantes and Schneiderman[4] evaluated 16 studies which had been designed to determine the value of anticoagulant therapy in the treatment of cerebral vascular disease. They concluded that each study lacked some information necessary to insure comparability of the control and treated patients and that in mid-1975 the value of anticoagulation for treatment of strokes still had not been established. This lack of pertinent and uniform baseline information also applies to many studies designed to evaluate medical treatment of TIAs.

Age, sex, race and geographic site of residence may affect the natural history of cerebral vascular disease. These, in addition to conditions such as high blood pressure and atherosclerosis, influence prev-

* Department of Medicine, Division of Hypertension and Clinical Pharmacology, Medical College of Georgia, Residence III, Room 124, Augusta, Ga. 30902.

TABLE I

BASELINE DATA GIVEN IN STUDIES OF THE NATURAL HISTORY AND EFFICACY OF TREATMENT OF CEREBRAL VASCULAR DISEASE

Author	No. Patients	Age	Sex	Race	BP	Site of Residence	History Prev. Stroke	History Heart Disease
Baker[1]	443	+	+	+	+	−	+	−
Baker[3]	60	+	+	−	+	−	+	+
Baker[2]	79	+	+	+	+	−	+	+
Goldner[5]	140	+	+	−	+	+	+	+
Harrison[6]	2	+	+	−	+	−	−	+
Heinkinheimo[7]	430	+	+	−	−	+	−	−
Marshall[9]	26	+	+	−	+	−	−	−
McDevitt[11]	100	−	−	−	−	−	−	−
Millikan[12]	7	+	+	−	+	−	+	−
Millikan[13]	26	+	+	−	−	−	−	−
Pearce[14]	37	+	+	−	+	−	+	−
Siekert[16]	335	−	−	−	−	−	−	−
Siekert[15]	230	+	−	−	−	−	−	−
V.A. Coop[17]	155	−	−	−	−	−	−	−
Whisnant[18]	198	+	+	−	+	+	+	−

The efficacy of coumadin derivatives or aspirin in the prevention of strokes is still in question.

alence, incidence and consequences of the TIA syndrome. Therefore, this data should be included in each study in order that the baseline or "risk" factors for the control and treated group can be compared. However, most studies did not report and/or correlate all these factors which may influence the incidence of TIA, stroke and death from thromboembolic disease. (See Table I.[1-3, 5-7, 9, 11-18]) In addition, the presence or absence of hypertension and the ability of patients to adhere to the prescribed therapeutic program and return for follow-up were not mentioned in many reports. These factors in particular may affect treatment chosen for each individual patient and may lead to bias for inclusion of patients in treated or control groups.

When anticoagulants are used, the double-blind method of study is difficult to follow completely, because of the need to adjust medication doses based on prothrombin times. However, the double-blind method is not essential if only objective indices of treatment success or failure are used, i.e. death or the occurrence of stroke.

The persistence or incidence of TIAs is more subjective but could be used as an index of treatment success and failure, if one physician regulated the anticoagulation dose and another recorded the number of TIAs experienced. The lack of strict randomization and absence of information concerning risk factors presents more of a problem in evaluating most of the studies, than failure of many investigators to follow a double-blind method of study.

The differences in the design and baseline data of each study prevents us from pooling the data from each report and making a final conclusion regarding the value of anticoagulation or aspirin therapy of TIAs. It appears best to evaluate each paper separately, and determine how many individual studies show a statistically significant decrease in the number of TIAs, strokes and/or deaths in patients with TIAs who were anticoagulated as compared to those who did not receive coumadin derivatives. In addition, the uncertainty of the prognosis of transient ischemic episodes makes assessment of the value of therapy extremely difficult.[8]

Table II[1-3, 5, 8, 10, 11, 14-18] contains a summary of the occurrence of stroke and death in patients with TIAs who were not treated with anticoagulants. The wide range in the prevalence of stroke in the different studies is probably due to both differences in duration of the studies and the unequality of baseline parameters, as well as the relatively short time and small numbers of patients that were followed. We attempted originally to calculate the number of CVA's and deaths per 1000 population per year in order to obtain a figure that could be used for comparing these studies of varying size and duration to each other. However, the length of follow-up of patients in a single study varied as much as three months to eight years,[2] so an average period of follow-up could not be determined for many of these studies. Thus, estimated or projected incidence rates for stroke or death could not be derived.

In four of five reports (see Table III[1, 3, 11-17]) patients with TIAs who were anticoagulated had fewer TIAs than patients who were not treated. Applying Chi square analysis to this data shows the difference in the number of TIAs between treated groups and controls was statistically significant in three studies: the VA Cooperative Study[17] and studies by Baker et al.[1, 3] and Siekert et al.[15] McDevitt et al.[11] reports number of TIAs rather than number of patients having TIAs, so this data could not be analysed by the Chi square test. Reports in which no TIAs, CVAs or deaths were reported for either the control or treated groups were not evaluated statistically.

The two studies by Siekert[15, 16] were the only ones cited in Table III which show a statistically significant decrease in the number of CVAs in patients who had TIAs and were anticoagulated compared to those not treated. None of the reports show a difference in number of deaths between treated and nontreated TIA patients.

Heikinheimo and Jarvinen concluded that there is no evidence that aspirin has any prophylactic benefit in thromboembolic-arteriosclerotic disease of the cerebral arteries in the aged.[7] No data was presented specifically with respect to TIA patients and numbers of TIAs. Harrison et al. recorded a decrease in the frequency of attacks of amaurosis fugax in two patients treated with aspirin.[6] To date, there is insufficient data available to indicate if aspirin is beneficial or not in preventing TIAs, strokes and/or death in patients with TIAs.

Table IV summarizes the data available regarding coumadin derivatives for treatment of TIAs. Three studies show a statistically significant decrease in number of TIAs with treatment; two indicate there is a significant decrease in number of strokes, and none show a decrease in mortality. Although

TABLE II

NATURAL HISTORY INCIDENCE OF CVA AND DEATH IN PATIENTS WITH TIA

Author	Patients	Range or Avg. Duration Study	CVA No.	CVA %	CVA Deaths No.	CVA Deaths %	Total Deaths No.	Total Deaths %
Baker[3]	30	1 – 8	4	13	0	0	5	17
Baker[1]	20	0.2 – 3.5	4	20	1	5	2	10
Baker[2]	79	0.3 – >8	17	22	2	2	17	22
Goldner[5]	140	15	43	31	27	19	84	60
Marshall[10]	64	<1 – >10	8	13	2	3	11	17
Marshall[8]	61	0.3 – >7	1	2	1	2	7	11
McDevitt[11]	100	0.5 – >6	2	20	NG		NG	
Pearce[14]	20	0.1 – 1.8	2	10	1	5	3	15
Siekert[16]	160	3 – 8	51	32	18	11	44	28
Siekert[15]	40	1 – >5	16	40	3	8	7	18
V.A. Coop[17]	15	1.1	0	0	0	0	0	0
Whisnant[18]	118	5	53	45	NG		NG	

TABLE III

EFFICACY OF ANTICOAGULATION IN TIA PATIENTS

Author	Range or Avg. Duration Study	TIA No. Patients Control	TIA No. Patients Treated	CVA Control	CVA Treated	Total Deaths Control	Total Deaths Treated
Baker[1]	0.2 – 3.5	6/20	1/24+*	4/20	1/24	2/20	5/24
Baker[3]	<1 – 8	14/30	10/30	4/30	2/30	5/28	6/27
McDevitt[11]	0.5 > 6	N	G	2/10	0/10	N	G
Millikan[13]	NG	NG	1/5	NG	0/5	NG	0/5
Millikan [12]	NG	NG	1/7	NG	0/7	NG	0/7
Pearce[14]	0.1 – 1.8	9/20	10/17	2/20	1/17	3/20	0/17
Siekert[16]	3 – 8	N	G	58/160	20/175†	44/160	40/175
Siekert[15]	1 – >5	10/40	4/115†	19/40	10/115†	7/40	16/115
V.A. Coop[17]	1.1	8/15	1/22†	0/15	1/22	0/15	2/22

CVA—Cerebral infarct and/or hemorrhage.
NG—Not given.
+—Average No. patients having attacks each month for first 4 months.
*—$P < 0.05$.
†—$P < 0.001$.

bleeding complications may accompany anticoagulation therapy of patients with TIAs, there is no statistically significant evidence to show that use of anticoagulants leads to an increased incidence of stroke from cerebral hemorrhage or an increase in overall mortality.

It has been noted that patients with cerebrovascular disease often have many contraindications for anticoagulation. For example, they may have physical disabilities or disturbances in mental function which impair their ability to adhere to a medical regimen or return for follow-up or some may have labile high blood pressure. These medical and surgical illnesses frequently modify decisions concerning anticoagulation. In a VA cooperative study, only 11% of all patients were found to be suitable for anticoagulation. In most studies, this suggests that anticoagulation therapy can be initiated in only a limited number of patients. Although the percent of patients with TIAs that are candidates for anticoagulation is small, more data is needed to define the role of anticoagulant therapy in treatment of TIAs. Strict randomization of patients and consideration of risk factors in treated and control groups need to be evaluated before statements can be made regarding the prevention of cerebral infarction and risk of cerebral hemorrhage of patients treated with coumadin derivatives.

Data available at this time indicates that mortality does not appear to be decreased significantly by medical therapy, but larger numbers must be studied and risk factors correlated before definitive statements regarding the death rate after anticoagulation of patients with TIAs can be made.

Summary

The controversy that remains regarding the optimal treatment of patients with transient ischemic attacks (TIAs) emphasizes the need for a well controlled clinical study to better assess the efficacy of anticoagulation and aspirin in the treatment of TIAs. That one has not been accomplished in 20 years is an indication of the difficulty involved in such a study.

The number of patients with TIAs that are candidates for anticoagulation is very small, which makes the evaluation of treatment regimens nearly impossible for one investigator.

Although there is some data to support the use of anticoagulants for prevention of TIAs, more data is needed to better define the risks versus benefits of therapy in these patients. The efficacy of coumadin derivatives or aspirin in patients with TIAs for prevention of stroke is still in question. No study evaluated in this report showed that medical therapy of TIAs decreased over all mortality.

TABLE IV

STUDIES SHOWING BENEFIT FROM ANTICOAGULANT THERAPY IN TIA PATIENTS

No. TIAs	No. CVAs	No. Total Deaths
3/5	2/5	0/4

Numerator = No. of studies showing a statistically significant benefit from anticoagulant therapy.
Denominator = No. of studies statistically evaluated.

BIBLIOGRAPHY

1. Baker, R. N., Broward, J. A., Fang, H. C., Fisher, C. M., Groch, S. N., Heyman, A., Karp, H. R., McDevitt, E., Schneinberg, P., Schwartz, W. and Toole, J. F.: "Anticoagulant Therapy in Cerebral Infarction," *Neurol.* 12:823-835, 1962.

2. Baker, R. N., Ramseyer, J. C. and Schwartz, W. S.: "Prognosis in Patients With Transient Cerebral Ischemic Attacks," *Neurol.* 18:1157-1165, 1968.

3. Baker, R. N., Schwartz, W. S. and Rose, A. S.: "Transient Ischemic Strokes," *Neurol.* 16:841-847, 1966.

4. Cervantes, F. D. and Schneiderman, L. J.: "Anticoagulants in Cerebrovascular Disease," *Arch. Int. Med.* 135: 875-877, 1975.

5. Goldner, J. C., Whisnant, J. P. and Taylor, W. F.: "Long-Term Prognosis of Transient Cerebral Ischemic Attacks," *Stroke* 2:160-167, 1971.

6. Harrison, M. J. G., Marshall, J., Meadows, J. C. and Russell, R. W. R.: "Effect of Aspirin in Amaurosis Fugax," *Lancet* 2:743-744, 1971.

7. Heikinheimo, R. and Jarvinen, K.: "Acetylsalicylic Acid and Arteriosclerotic-Thromboembolic Diseases in the Aged," *J. Am. Ger. Soc.* 19:403-405, 1971.

8. Marshall, J.: "The Natural History of Transient Ischemic Cerebrovascular Attacks," *Q. J. Med.* 33:309-324, 1964.

9. Marshall, J. and Reynolds, E. H.: "Withdrawal of Anticoagulants From Patients With Transient Ischemic Cerebrovascular Attacks," *Lancet* 1:5-6, 1965.

10. Marshall, J. and Wilkinson, I. M. S.: "The Prognosis of Carotid Transient Ischemic Attacks in Patients With Normal Angiograms," *Brain* 94:395-402, 1975.

11. McDevitt, E., Carter, S. A., Gatje, B. W., Foley, W. T. and Wright, I. S.: "Use of Anticoagulants in Treatment of Cerebral Vascular Disease," *JAMA* 166:592-597, 1958.

12. Millikan, C. H., Siekert, R. G. and Shick, R. M.: "Studies in Cerebrovascular Disease. V. The Use of Anticoagulant Drugs in the Treatment of Intermittent Insufficiency of the Internal Carotid Arterial System," *Mayo Clin. Proc.* 30:578-586, 1955.

13. Millikan, C. H., Siekert, R. G. and Shick, R. M.: "Studies in Cerebrovascular Disease. III. The Use of Anticoagulant Drugs in the Treatment of Insufficiency of Thrombosis Within the Basilar Arterial System," *Mayo Clin. Proc.* 30:116-126, 1955.

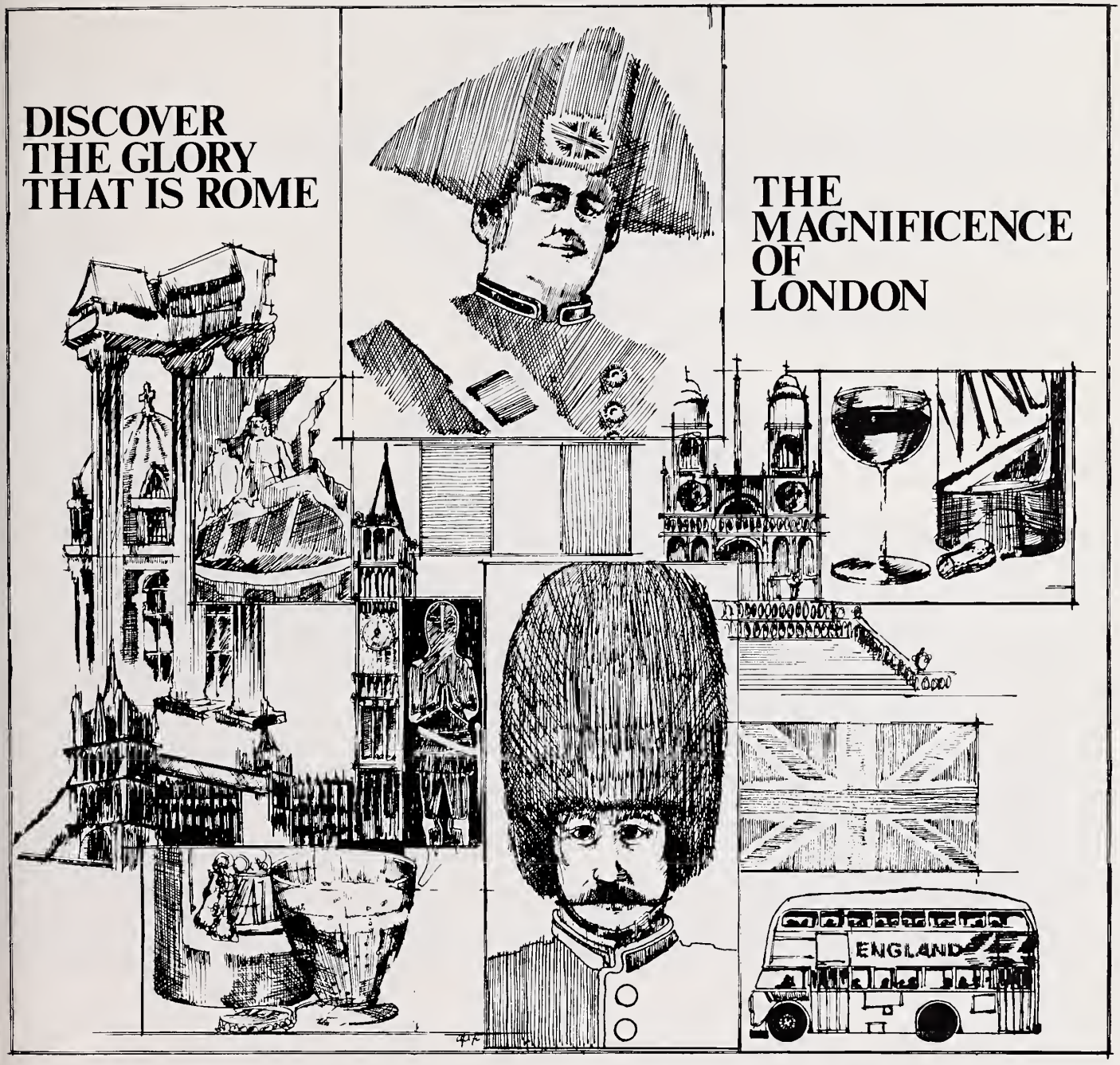
14. Pearce, J. M. S., Gubbay, S. S. and Walton, J. N.: "Long-Term Anticoagulant Therapy in Transient Cerebral Ischemic Attacks," *Lancet* 1:6-9, 1965.

15. Siekert, R. G., Millikan, C. H. and Whisnant, J. P.: "Anticoagulant Therapy in Intermittent Cerebrovascular Insufficiency," *JAMA* 176:19-22, 1961.

16. Siekert, R. G., Whisnant, J. P. and Millikan, C. H.: "Surgical and Anticoagulant Therapy of Occlusive Cerebrovascular Disease," *Ann. Int. Med.* 58:637-641, 1963.

17. V.A. Cooperative Study: "An Evaluation of Anticoagulant Therapy in the Treatment of Cerebrovascular Disease," *Neurol.* 11:132-138, 1961.

18. Whisnant, J. P., Matsumoto, N. and Elveback, L. R.: "The Effect of Anticoagulant Therapy on the Prognosis of Patients With Transient Cerebral Ischemic Attacks in a Community," *Mayo Clin. Proc.* 48:844-849, 1973.



Two of the world's most incomparable cities are within your reach in 1977 You'll have 10 days in which to explore and experience the excitement of both worlds. **Rome,** the "Eternal City" with its endlessly fascinating museums, art galleries, churches and palaces, Roman gardens and fountains. **Rome,** the city where "la dolce vita" began and shows no sign of ending.

London a kaleidoscopic mixture of architecture centuries old, mixed well with the modern look of today . . . Piccadilly Circus, Hyde Park, Carnaby Street, Soho, St. Paul's Cathedral, Buckingham Palace — all names you've read or heard.

And, for the first time, we are able to make a special limited **"air fare only"** offering at a price considerably lower than regular economy air fares.

Why not plan, now, to make all the sights and sounds of Rome and London more than what you've read or heard. Make them both a part of your life.

Get all the details by sending the coupon below.

Ten Days departing Atlanta October 18 thru October 27.

ROME·LONDON DISCOVERY

Land/Air Package:	**$898**
Air only Package:	**$549**

Send To:
Medical Assoc. of Atlanta
875 W. Peachtree St., NE
Atlanta, Georgia 30309

Please rush me a Rome-London Discovery Brochure

NAME

HOME ADDRESS

CITY/STATE/ZIP

Four areas in which health cost can be controlled are discussed and recommendations are made.

Report from MAG's Committee on Cost Accountability

MEMBERS OF THE COMMITTEE/HARRISON L. ROGERS JR., M.D., *Chairman**

IN CONSIDERING the ways in which the cost of health care might be controlled, the Cost Accountability Committee considered four major areas which influence the cost of health services.

1. **Physicians** must look at the cost of health care. They must be aware of the cost of the services ordered. This would include checking into the necessity for continued testing and coordination between physicians on tests ordered for a patient and between the physician's office and the hospital, so there is no duplication.

Medical schools should emphasize somewhere in their curriculum the cost of medical care. It should be recognized that physicians in training order greater numbers of tests and procedures, so their orders particularly should be monitored.

2. In many cases, **hospital facilities** are inappropriate and inefficient to perform certain procedures. Such procedures might be better done in a less costly setting such as the physician's office or in the outpatient department rather than on an inpatient basis. The hospital should carefully evaluate bills sent to insurers and to patients to be certain that the patient had actually received the services they had been billed for. The hospital ought to provide some mechanism for periodically informing the physicians of the charges being made for procedures provided to their patients.

3. The **health insurance industry** has taken a relatively responsible position in controlling the cost of health care. They advise their subscribers of how to keep health care costs down. In addition to this, however, the insurers ought to emphasize their outpatient coverage so that the individual will get as much of his services provided there as possible, as opposed to on an inpatient basis. Labor and management should make an effort in the use of deductibles or of co-insurance as a method for controlling utilization. The health insurer can assist the physician in controlling utilization by advising labor and management of the magnitude of the problem, when the physician is faced by an over-demanding patient or family.

4. In the long run, it is only **the public** who can have a long term effect on the cost of health care. Only if they drive with greater care, eat better, quit smoking, restrict alcohol intake, and agree with strict policies for use of services and facilities will utilization of health services decrease.

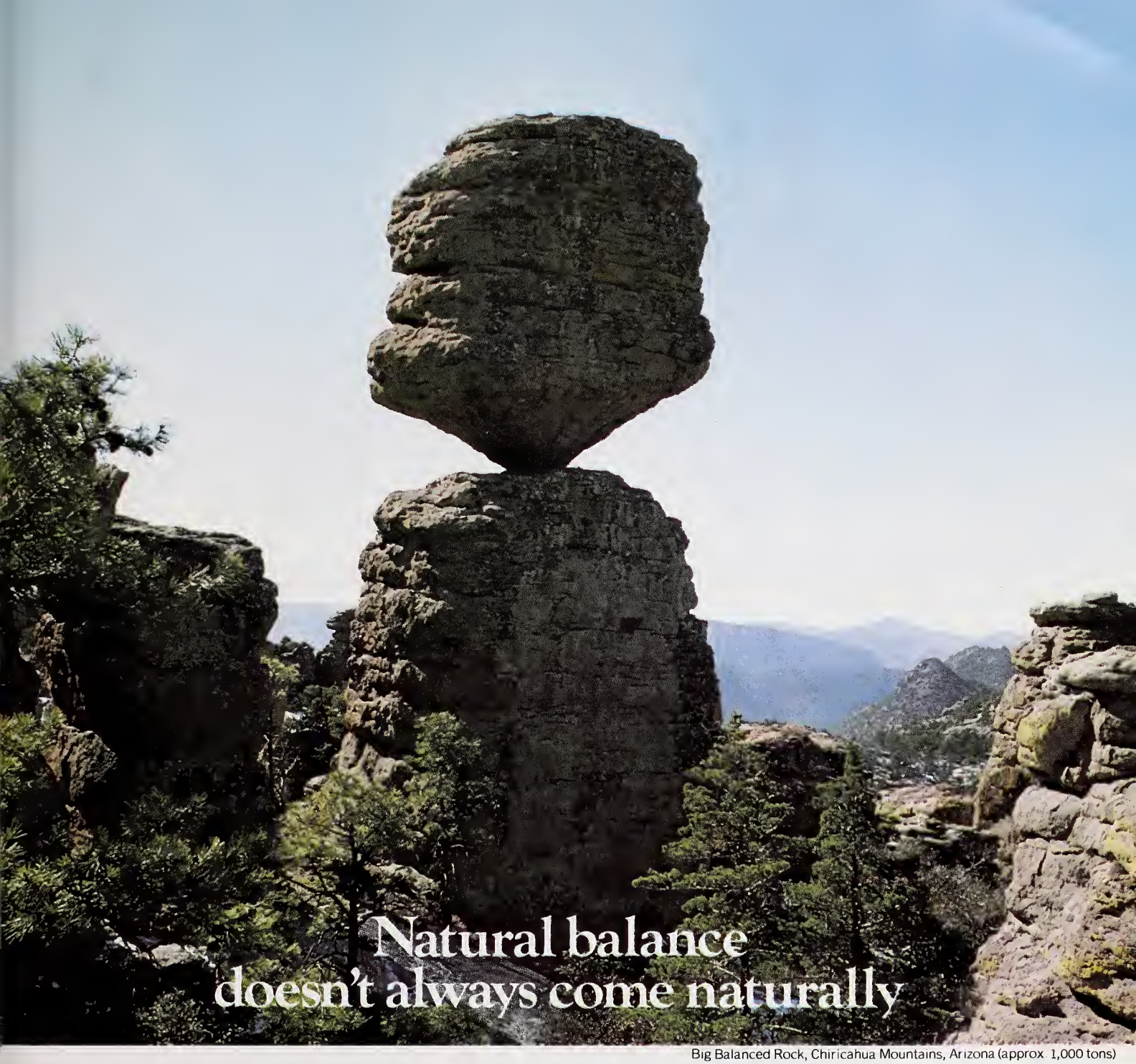
Controlling Hospital Costs

The major impact to be made in the area of cost containment must be in the hospitals. This can only be done at the local level through the efforts of individual physicians, hospital personnel and patients. The Committee agreed that it could not do much directly to reduce cost. This committee could be useful in preparing responses to medicine's critics. Also, it could develop informational items for newspapers, radio, TV and a general public relations approach to emphasize the concern of providers in reducing costs.

It is obvious that both management and labor have become more and more concerned with rising health care costs. Representatives of these groups could become involved with providers in an effort to look at this problem. It was suggested that on a regional or local basis, the county medical society and other provider representatives get together with labor, management and the media to look into rising health care costs in their areas and determine what

---

* Members of the Committee are: H. Duane Blair, M.D.; B. W. Forester, M.D.; Ronald Frost Galloway, M.D.; James R. Logan, M.D.; G. Bertling Smith, M.D.; Adam R. Jablonowski, MAG staff representative.
Dr. Rogers' address is Suite 601, 1938 Peachtree Rd., NW, Atlanta, Ga. 30309.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25


(meclizine HCl) 25 mg. Tablets
for vertigo*

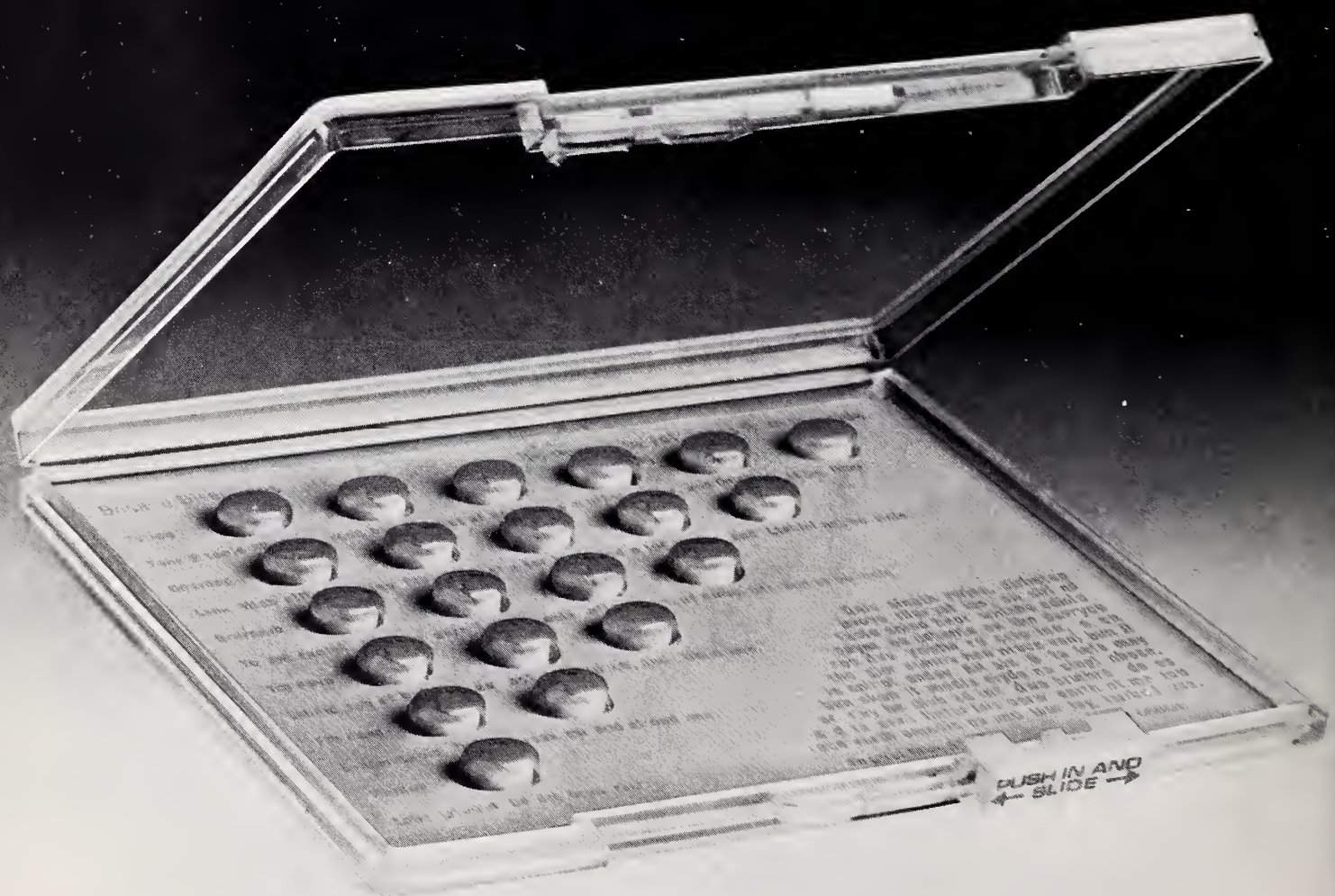
Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



*Trademark

J 5741-4

©1977 The Upjohn Company

should be done in order to reduce rising costs or to moderate the increases occurring.

It was suggested that out-patient benefits with low deductible attached, while high deductible and co-payment for in-patient care was included, might be a method for stimulating the use of lower cost care by patients. Representatives of the Blues pointed out that this was an extremely complex field and that any effort made in an area such as this had to be analyzed thoroughly, because it was possible that another aspect of the health care delivery system would be adversely affected. The Committee believed that there should be an effort made to eliminate the first dollar coverage under health insurance plans. Also, deductibles and co-insurance should be encouraged, not only for private coverage but also for Federal programs like Medicaid and Medicare.

Another area in which the hospitals could reduce costs is in efforts with patients' self care. This would include expansion of ambulatory care units in the hospital. There should be renewed emphasis placed on the use of cafeterias, self-medication by the patient, and a general effort to have the patient take care of himself while hospitalized.

Utilization review should receive greater emphasis in the hospital and be better coordinated so that problem diagnoses, physicians and patients, could be more easily identified and reviewed. The committee felt that an upgrading of all medical audits should be undertaken in the hospital and that utilization review should cover 100% of the patients. There was general agreement that hospital controls are much better than control efforts made by insurance companies or government. The insurance company or government can sometimes be used as an "excuse" by the physician in order to explain to the patient that certain services cannot be covered. It was suggested that insurers consider elimination of such items as private room coverage, private duty nursing, etc., unless alternative services such as intensive care units are not available in the hospital.

Government interference in medical practice through a requirement that certain tests be performed was brought up as another example of added costs. It was suggested that tests for admission to hospitals, extended care of nursing homes be examined to be sure that duplicate testing was not being done and considering whether or not certain tests were at all needed prior to or at admission.

Review of technical advances was felt to be necessary in order to control rising costs. A physician ought to look at his practice and the type of patients he has, to determine whether he really needs expensive procedures performed by new technologically sophisticated equipment. He should determine whether the test results he obtains from this equipment will make any difference in his diagnosis or treatment of patients. It was also pointed out that procedures such as kidney dialysis both on an in-patient and home basis, ought to be looked at from the point of view of the quality of life available to the individuals undergoing this procedure. Certainly there is a significant cost differential between in-patient and home treatment which also ought to be examined. It was suggested that possibly the Medical Care Foundations could become involved in developing guidelines for new technologies such as CAT scanners.

Out-patient surgical services seem to be an area which can help reduce medical care costs. Ambulatory surgical centers are not generally available in Georgia and are not licensed. There were some questions raised whether or not licensure was the appropriate way of dealing with the accreditation of, or making a determination of the quality of services provided in these facilities. It was suggested that the individual third party payers might establish some sort of agreement with the ambulatory surgical centers rather than providing licensure for the facilities.

The Committee reviewed the possible ways in which local accountability committees could help their hospitals reduce costs. It was suggested that the hospitals post the charges for the 20 most common procedures so that the physician could easily see what the cost of services was. It was also thought that by listing the cost of services on the patient's chart for a period of time, the physician might become more conscious of what his patients were being billed.

Sending a copy of the hospital bill to the physician from the hospital might be another way of alerting the doctor to the cost of care. Simply maintaining a listing of tests, lab procedures, x-rays, and keeping their costs posted would be a method of informing staff members who order these tests as to what they are really doing in terms of adding to the bill of the patients. This could be done on a departmental basis in larger facilities and an overall hospital basis in smaller facilities. The Committee strongly supported the concept of the hospital staff looking into the endorsement of pre-admission testing.

Another area which may be a very significant impact on health care is the HSA. The Committee felt that physicians should be strongly encouraged to participate in the activities of the HSA's in their area.

Recommendations

In conclusion, the Committee suggested that the following should be made as recommendations to the

MAG House of Delegates as part of this Committee's report:

1. Support the establishment of regional councils on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals and the media. These councils are to serve as a continuing forum for education of both the public and providers.

2. Urge insurance companies to eliminate first dollar coverage and to institute the use of deductible and co-insurance. Out-patient benefits should be expanded with consideration given to higher deductible and co-payment for in-patient care. The concept of co-insurance and deductible should be extended to Medicaid and Medicare.

3. Endorse expansion of utilization review methods to cover 100% of hospital patients. Medical audit procedures should be upgraded with assurance that findings are brought to the attention of the medical staff for their consideration of changing hospital procedures as indicated.

4. Support restrictions on costly additional services such as private room and private nurse services by insurance carriers. Elimination of duplicate testing for admission to the hospital, extended care or nursing home facilities should be strongly encouraged rather than required, as is often the case in government programs.

5. Hospitals should be urged to consider introducing or expanding self-care by the patient, including self-medication, room care, and use of cafeteria facilities.

6. Hospital medical staffs should be encouraged to inform themselves about costs of medical care in their facilities. This might include:

a) Posting the charges for the 20 most common procedures performed in the hospital so that physicians will see the prices in a prominently placed display.

b) On a periodic basis listing on his chart the cost of services provided to the patient.

c) Sending a copy of the hospital bill to the patient's physician by the billing office.

d) Keeping the medical staff members informed on hospital costs such as lab procedures, x-rays, tests, etc.

e) Establishing a "Cost Control" Committee of the medical staff or assign this to an existing committee.

7. Encourage local physician involvement in health systems agency activities through membership on task forces, committees and boards of directors, to assure that the best interests of patients are considered in all HSA decisions.

ADDENDUM: This Committee report was presented to Reference Committee D at the Annual Session of MAG. The reference committee adopted the report with the following changes: Recommendation 1, which calls for MAG to "support the establishment of regional councils," was changed to read "support the establishment of community meetings on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals, the media and consumer interest groups."

Recommendations 2-8 were accepted as is, and a ninth recommendation was added: "that the Committee on Cost Accountability continue to study the issue of cost accountability *with particular reference to ways in which expenditures for health services can be influenced by (1) high deductible insurance, (2) making sure that the patient receives the services he pays for, (3) maintaining restraint on the rise in physician fees, (4) continuing to upgrade the quality of care, and (5) denying loudly the concept that medical care is a public utility.*

The House of Delegates accepted the Committee report as amended by the Reference Committee.



By the time she can have a baby of her own, will she be able to afford to?

Hospital and doctor costs for having a baby have risen from a national average of $425 in 1967 to nearly $1,150 today.

Unless something is done about it, people may see a $3,400 bill when they have a baby in 1997.

You couldn't afford that. Neither could we.

That's why Blue Cross and Blue Shield Plans, working with doctors and hospitals across the country, have introduced a number of programs designed to help slow down dramatically rising health care costs.

What we are doing to hold down rising health care costs.

Many Blue Cross and Blue Shield Plans have programs that allow qualified patients to be discharged from the hospital sooner. The hospital provides whatever medical services they need *at home*. At a cost far lower than that of an extra day — or days — in the hospital.

Under another new program, some surgical patients scheduled for a hospital stay can have their lab and X-ray tests done as outpatients. Instead of spending a $130 day in the hospital waiting for test results, the patient can return home or even go back to work until the results are in.

A third cost-cutting program in many areas is encouraging certain kinds of surgery to be performed on an "in by nine, out by five" basis. By getting the patient back home the same day, it's easier on him. And on his pocketbook, too.

We're also working with doctors' review committees to make sure that the medical procedure and tests provided are really needed. It's a cooperative effort that's saving us all millions of dollars each year. And we're also working with various planning agencies to help make sure only needed services are available.

All of these are steps that can help hold down rising health care costs. Whether or not they will depends on the cooperation of each and every one of us.

What you can do to help.

The closer you watch every health care dollar, the less increase you may have in the rates you pay for health coverage. Ask for — and *use* — the kind of cost-cutting programs we've described here.

Because only if doctors and hospitals realize that *you* are as vitally concerned as we are — and they are — will these programs be offered and used on a widespread basis.

You can also join the more than 90 million people who subscribe to not-for-profit Blue Cross and Blue Shield Plans. We annually return over ninety cents of every dollar paid in for the health care of our members, and never cancel a single person because of a poor health record.

If you'd like to know more about what we're doing to hold down costs, and what you can do to help, write Box 4445, Atlanta, GA 30302 for our free booklet, "How All of Us Can Help Each of Us Hold Down Health Care Costs."

Blue Cross Blue Shield
of Georgia
Atlanta/Columbus

All of us helping each of us.

A physician shares his observations and discusses specific recommendations.

Cost Containment—At All Costs!

HARRISON L. ROGERS JR., M.D., *Atlanta**

As Chairman of the MAG Committee on Cost Accountability, I was asked to prepare an article on the subject for this issue of the *Journal*. By the time this appears, our MAG House of Delegates will have acted upon the recommendations of this Committee, favorably I hope, and a great storm of activity will be under way across the state. Your editor has also invited the views of a hospital administrator, a health insurance carrier and a government official. Their articles also appear in this issue.

The MAG Committee was constituted by the 1976 House of Delegates and charged to investigate health care costs and subsequently make recommendations for MAG action. Members of the Committee were aware of growing concerns by the public and to a lesser degree by health care providers in the matter of costs, but were totally unprepared for the deluge of reports, articles, speeches and legislative proposals on this issue. The files of our Committee are literally bulging with information collected during this year and consequently the charge to investigate rather is a charge to attempt to assimilate all the available information. In addition to our own efforts, the AMA has a nationally constituted cost committee whose report will be issued this year.

Public concern with health care, its accessibility, quality and cost has mushroomed during the same period of time that most of the spectacular advances have been made in the product which we as physicians deliver. This is certainly not happenstance, for with advances in drugs and devices, as well as diagnostic and therapeutic measures, all delivered in "deluxe" facilities, costs have risen geometrically. In 1966, Congress first passed Medicare, then Medicaid, to provide for the financing of medical care to the elderly and the poor. Though many factors were important in the passage of these two laws, cost was of prime concern. Subsequent passage of the PSRO law in 1972, widely touted as a quality assurance program but more realistically a cost containment effort, was the next step. Public Law 93-641, signed into law by President Ford in 1975 as a planning law, is directed at control of the health delivery system and its attendant costs. Finally, with serious consideration of a national health plan or NHI, the administration and the Congress is responding to what they perceive to be a mandate to cope with health care costs.

With a price tag of 140 billion dollars for all health care in the U.S., none would deny that efforts to control the escalation of this amount are indicated and are indeed late in coming. However, to see a federally operated, controlled and financed system as the answer to this problem is sheer folly. Where has the federal government operated any program more efficiently or less expensively than a comparable program operated by private industry? The U.S. is often denigrated for its role as the last major industrial country without "socialized medicine," but when we look at the cost as well as the quality of care in such places as Great Britain, this accusation should turn to an accolade! "Cost containment at any cost" by federalizing our health care system is a cruel hoax to perpetuate on the American taxpayer who would in fact be destined to receive less and pay more.

William Lilley III, former director of the President's Council on Wage and Price Stability, has been quoted in the *American Medical News* (March 14, 1977) as stating: "As presently structured, there are few incentives within the provider system to

* Chairman, MAG Committee on Cost Accountability. Dr. Rogers' address is Suite 601, 1938 Peachtree Rd., NW, Atlanta, Ga. 30309.

control costs, to economize, or to weigh the costs of a proposed action—whether it is the purchase of new equipment, the expansion of a hospital, or the selection of a course of treatment—against its benefits . . .

"We have seen, in every phase of our investigation into this problem, that cost-control incentives proposed by the private sector—that is, by industry and labor—promise to be more effective than those imposed by the multitude of government agencies which have attempted to tackle the problem. Numerous industry and labor efforts have been aimed at controlling costs while maintaining quality. . . .

"The private sector is motivated by economic incentives which the government will simply never share.

"We have heard consumer groups and labor organizations say that their members, and the American people generally, are becoming increasingly unwilling to devote an ever larger portion of their personal income to health care. When that day comes, we believe the people of this country will turn to the federal government and demand that it solve the problem. Absent any major changes in the structure of the medical care system between now and then, the federal government will step in, and when that happens, we are going to be faced with a permanent problem which will defy solution. . . .

"This does not have to happen. An alternative to federal control of the health care system is available if promptly seized: a concerted and unified effort on the part of industry and labor to control costs. We have been very favorably impressed with efforts we have seen initiated to date. . . .

"Witnesses at the hearings told us of strong opposition from a highly respected, well-organized medical establishment. Private efforts at cost-control are difficult to undertake in the face of this opposition. But we remain convinced that the goal of quality health care, at reasonable costs, is attainable within the context of a largely privately disciplined system. Indeed, it is only within the context of the private system that it is attainable."

Another view of the Congressional perception of the problem of rising health care costs was voiced by Alice Rivlin, Ph.D., director of the Congressional Budget Office, who said "Congressional concern about the cost of health care and the excessive use of health care resources has now overridden concern about widening access to the system . . . clearly, we're getting more for our money, but there's a widespread concern that we may be getting too much."

With this background, the Committee agreed with the magnitude and importance of the problem. We know of no "strong opposition" to cost control efforts from within organized medicine; indeed the AMA, as well as many state medical associations have already embarked on active cost containment efforts. We agree completely that improvement can only come from within the private system and have witnessed efforts by the American Hospital Association as well as health insurance carriers to slow the precipitous rise in health care costs. However, we find fault with Mr. Lilley's conclusion that improvement can only be attained with a concerted effort by industry and labor. The provision and receipt of health care involves this large segment of the American public, but in addition, the entire population represented by the Congress, the providers (both individual physicians and hospitals) and the health insurance carriers. As we viewed the problem and made recommendations for its solution, it was apparent that each of these components of our society has a special opportunity and a special responsibility in solving the problem as follows:

1. The physician has literally a vital responsibility, for it is his lot to assess the diagnostic needs of his patient and then subsequently direct the therapeutic measures to be employed. The physician has traditionally assumed this role as the prime advocate of his individual patient with only secondary consideration given the cost. Indeed, in health our patients are concerned about increasing premiums of health insurance, but when illness presents, "money is no object" is the usual admonition.

It is his responsibility to determine initially whether disease is present and what diagnostic studies are indicated to confirm this or disprove it. Whether these studies should proceed in the office or in a hospital is a critical decision with regard to the cost involved, for the latter route immediately raises the cost precipitously. Whichever locus is selected, the physician's determination of how the diagnostic evaluation should be carried out is important. He may simply order "blanket" studies, special procedures and consultations, or instead choose the narrower path which he feels will be the most fruitful. In evaluating each procedure to be ordered, the potential value to the patient, possible harm involved and certainly the cost of each must be evaluated. Too few physicians have any concept of the cost of these studies individually or the impact of this total cost on the "third party" who may be paying the bill. A program directed at informing all physicians of these specific charges would certainly prove an eye-open-

"No one would deny that efforts to control the escalation [of health costs] are indicated and indeed late in coming."

ing experience, as would a copy of an occasional patient's hospital bill. Thorny diagnostic problems, the threat of malpractice suits and other factors may dictate the "blanket" approach, but consideration in each instance should be deliberate. Increased use of utilization review may well serve to bring unsuspected problems to light.

When hospitalization is necessary, careful planning will minimize delays. Admission of elective patients before weekends or holidays has been well documented as an important factor in higher hospital bills. More difficult to document are the wasted hospital days caused by delays in consultation or in getting on the operating room schedule—days which might have been saved by planning ahead. Early planning for discharge can also be beneficial so that the patient, his family or perhaps the nursing home to which he is being sent can be prepared.

The physician has always had the responsibility for his patients care; this is the job for which he has been trained. Today, however, society is telling us that we must also consider the cost. The physician alone is able to weigh benefits and liabilities, as well as cost.

"[Perhaps] the most promising [recommendation] is the establishment of regional intrastate councils on Health Care Costs."

2. Hospital charges account for 40 percent of the "health care dollar" and so have a particular responsibility for frugality. A subsequent article focused on hospitals addresses specific areas of concern, but certainly good management procedures and resistance to unneeded but glamorous and costly services will require attention.

3. Our health insurance carriers have a difficult task, i.e., to design the best benefits package for the least in premiums and then be able to market this product. (I trust the problem will be solved by our author from the industry whose article follows.) All studies would suggest that a mechanism must be developed by the carriers to encourage utilization of the least costly and most effective means of delivery of health care. Some means of "cost-sharing" by the recipients of benefits would seem beneficial and this concept, if valid, can best be "sold" to business and labor alike by the carrier.

4. The Public, individually as well as collectively, via its elected governmental representatives, must assume its role as the single most important factor in the complex equation of health care costs. The collective public must keep its demands for health care, as well as promised benefits, related to our country's economic resources. Health care now accounts for 8.6 percent of our gross national product and is predicted to rise to 10 percent in the next few years. Our citizens must decide whether they can afford the deluxe health care which some of our federal programs mandate. Each government program, whether a "service" program or a "control" program, adds an unbelievable layer of administrative personnel—plus an ever-increasing paperwork burden—to both individual and institutional providers, adding to their cost of operation and ultimately to the "Health Care Dollar."

The public as individuals has a most important role in this equation. Our patients must first be informed of the magnitude of the problem, and then agree to act responsibly. They must agree to drive more carefully, for auto accidents and their inevitable costs are a major factor in health care costs. They must agree to eat more sensibly, drink less alcohol and finally agree—not just in theory, but in practice—to strict policies for use of services and facilities. Our patients must assume responsibility individually for curbing "voluntary" overutilization of either offices or hospitals. If a particular service can be offered equally well on an ambulatory basis as in the hospital, the former must be chosen. When the day of discharge has been selected on a medical basis, this should not be delayed for "social" reasons. When maximum recovery has been attained, our patients must not seek additional "sick leave," and requests for disability will have to be related to disease and not desire.

In conclusion, our committee felt that the magnitude of this problem precludes solution by any one or two of the listed groups. Each has a special role to play if this is to be a successful effort. We have given a number of specific recommendations in our report to the House of Delegates, but feel the most promising one is the establishment of regional intrastate councils on Health Care Costs. Included would be physicians, hospitals, health insurance carriers, labor, management, public representatives and the media. Continuing on an indefinite basis, these councils would provide a forum for education as to the problems, identification of new problems and hopefully solutions. I sincerely hope that the recently concluded House of Delegates has favorably considered our report and that our state is in the process of a cooperative attack on Health Care Costs.

Health Care Costs—Quo Vadis?

FRED R. HIGGINBOTHAM, *Atlanta**

Here's what Blue Cross and Blue Shield is doing to fight rising health costs.

"SURELY YOU'VE GOT to be kidding!"—"Another rate increase?"—"You raised our rates just last year."—"I don't see how we can afford to provide the same level of benefits. Can they be reduced to keep the rates down?"—"Why?—Why?—Why do the costs for health services keep going up faster than everything else?"—Questions and comments like these are heard many times each day at Blue Cross and Blue Shield of Georgia/Atlanta.

At the national, as well as the local level, our employer groups who pay the benefit dollars are expressing extraordinary concern and want to know what we are doing about costs. Our marketing force is faced with the character-building task of presenting 20, 30 and 40% rate increases year after year.

In any discussion relating to health care costs, it is important that we begin by accepting the fact that the continually escalating cost for health care services is a problem of gigantic nature. We must resist those who want to simply explain the cost problem as not very serious, and we must beware of those who are screaming "crisis" and want to blame doctors and hospitals for all the ills of our health system. Too many among us have been unable to resist easy generalizations about the problem and various proposed superficial solutions. We need to open our minds and face the problem analytically, armed with the facts that are available, while recognizing that broad gaps exist in our understanding of health economics.

A few statistics on Blue Cross and Blue Shield of Georgia/Atlanta susbscribers may be helpful. During the five-year period from 1971-76, the average amount we paid on a hospital claim increased from $432.31 to $851.43. This near doubling was accompanied by an increase in admissions from 143.0 per thousand subscribers to 170.5 during the same period. Currently Atlanta Blue Cross subscribers' utilization is one of the highest in the country at 895 days per thousand members, compared to a national average of 808. It is probably not a coincidence that utilization increased dramatically in 1973-74 following the period when many new beds were added to Atlanta hospitals.

Reasons Are Complex

The reasons for the rise in health care costs are complicated and involve inflation in the broader society, rising demands, government regulation, growing technology, and a vast number of other factors. Because the problem is complex, no easy solutions are possible; no panaceas are available for intractable problems. Financial "juggling," such as cost caps, front-end deductibles on insurance policies and changing physician reimbursement, has a role to play—but alone will not solve the problem.

We must not over-promise. Cost controls, cost accountability, cost containment, cost management, or whatever term is preferred will take time to be effective. Hundreds of hospitals, thousands of doctors, and millions of consumers are involved, and substantial changes in their behavior and its cost implications will come—not overnight, but rather after much hard work.

Must Act

Nevertheless, complexity and difficulty should not be used as an excuse for inaction. It is time to act

* President, Blue Cross and Blue Shield of Georgia/Atlanta, 3348 Peachtree Rd., N.E., Atlanta, Ga. 30326.

more boldly. One of the great strengths of the health field is its abundant—at times excessive—energy and vitality. It is full of competent, well-motivated physicians, executives, nurses, technicians, and institutions. The challenge now is to channel some of this innovative capacity into cost control and to get the rise in health care costs more in line with the cost of living increases and the growth of the Gross National Product. The field and its costs will grow, but the 15-17% increases of recent years must be moderated.

Cost containment should not be seen as solely the concern of government—as something to be imposed on the health field. Government has a role, but private institutions and voluntary initiative are more crucial and more likely to succeed over the long pull. The private sector has more flexibility, a better sense of the trade-offs between costs and quality, and continuing contact with patients and their needs and desires. Many of the difficult decisions that cost containment requires must be made at the community level.

The public requires that the cost issue be addressed, and the effectiveness of our response—the voluntary health financing and delivery system—is crucial to the success of the effort. We also need to find new ways of working together in this effort. Alone, the efforts of Blue Cross and Blue Shield Plans, the hospitals, the doctors or consumers, are destined to be ineffective. Cost containment will affect us all and requires joint effort and cooperation in new arenas.

The focus must be on public service. Doctors and organized medicine have a great heritage of dedication to the sick and injured and this is shared by many, including the non-profit Blue Cross and Blue Shield movement and most hospitals. We must unite around these goals and minimize our differences. Our future ability to serve hangs in the balance, for if we fail to work together and cope with the cost issue, there can be no question that more and more government intervention will result.

"The public requires that the cost issue be addressed, and the effectiveness of our response is crucial to the success of the effort."

The Blue Cross and Blue Shield Program

At Blue Cross and Blue Shield of Georgia/Atlanta because of our size and close relationship with providers of care, we feel we have a special obligation to work to contain costs. As a corporation we have been addressing these issues on a number of fronts.

1. **Administrative Costs**—Internally we have attempted to set our own house in order by controlling our administrative costs carefully. During the current year, our budget represents only 8.6% of total benefits, a substantial reduction over previous years.

2. **Benefits**—New benefits, including the Blue CHIP (Comprehensive Health Insurance Program) series —which provides for front-end deductibles and co-pay provisions to involve the consumer in the costs at the time of the service—have been created in an effort to promote cost consciousness. We intend to evaluate the impact of these benefit changes. In recent years, we have substantially broadened outpatient coverages to reduce the incentives for unnecessary hospitalizations.

3. **Work with Medical Care Foundations**—The Atlanta Plan works with the foundations for medical care, both the Metropolitan Atlanta Foundation for Medical Care and the Georgia Medical Care Foundation, in the areas of cost and quality of care, and substantial savings are achieved.

4. **C. O. B. (Coordination of Benefits)***—Our basic job is processing claims accurately (in accordance with the contract) and quickly. One specific aspect that influences costs is coordination of benefits, during 1976, we had documented savings of $5.1 million.

5. **Utilization Review**—An important facet of our effort in the near future will be a Utilization Review Program. During the latter part of 1976, we conducted with ten hospitals and their medical staffs a pilot program to test the cost-effectiveness of utilization review. Over 5,200 claims were reviewed and statistics on unnecessary days and costs were carefully recorded.

The results of this study are encouraging. On the one hand, only 4.3% of the total days were identified as medically unnecessary. This is a good result and is probably lower than many critics would have guessed. However, the study did conclusively demonstrate that a utilization review program could reduce this somewhat and be cost-effective, saving between one and two million dollars for Blue Cross and Blue Shield subscribers. Thus, utilization review can be a useful tool in saving one or two percent; this is desirable, but is an example of a program that should not be sold as the panacea. It is one effort; others are needed.

The Board of Blue Cross and Blue Shield of Georgia/Atlanta has voted to require utilization review in participating hospitals, effective January 1, 1978. A cooperative effort here by hospitals and doctors can be a substantive effort to demonstrate to

* Coordination of Benefits means that under the provisions of a group's contract, Blue Cross and Blue Shield coverage is coordinated with other coverage available to a subscriber through another group program. The purpose of the COB provision is to avoid duplicate benefit payment in cases of duplicate coverage.

20/150 H

20/100 EAR

20/70 ING IS

20/50 AS PRECIOUS

20/40 AS SIGHT HAV

20/30 YOU HAD YOUR HE

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP



WHEN BURNING PAIN COMPLICATES ACUTE CYSTITIS*

TURN IT OFF WITH AZO GANTANOL®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

*nonobstructed: due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis*, and, less frequently, *Proteus vulgaris)* in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

YOU MAKE THE CHOICE.



EMPIRIN® COMPOUND c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

C III

EMPRACET™ c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

C III

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

the public our genuine concern over costs.

The program will be designed to minimize paperwork and bureaucracy. Any hospital that demonstrates through good performance a given level of effective utilization will be granted a waiver similar to Medicare and no days or stays will be denied. Institutions which do not perform effectively and show poor utilization patterns will not receive waivers and our attention will focus there. We are sure that most hospitals do not over-utilize and will achieve waiver status.

"Complexity and difficulty should not be used as an excuse for inaction. It is time to act more boldly."

The best utilization review is done by the hospital and its medical staff, and our goal is to utilize this and design a program with a minimum of hassle for patients, doctors, hospitals, and the Blue Cross and Blue Shield Plan.

Other Steps

Other steps are planned. Recently a Board-level Cost Accountability Committee was created. It is chaired by W. Daniel Barker, Administrator of Crawford W. Long Memorial Hospital, and includes physician and hospital members, with consumers to be added in the near future.

This committee proposed an interim policy and program on costs which the Board has approved. This includes the following recommendations:

1. **Every hospital should have a cost containment committee or assign the functions to an existing committee.** This committee should be interdisciplinary, but physician involvement and commitment is basic. Physicians can be more aware of the cost consequences of their actions. How many know the cost of a day of care, a set of electrolytes, a G.I. series, a tetracycline prescription? An effort to publish hospital charges to the medical staff and distribute an occasional patient's bill to the attending physician can be beneficial.

2. **Community meetings on health care costs should be held.** All of us—doctors, carriers, hospitals, and consumers—must understand the cost problem better and participate in designing solutions. Real cost containment must have real impact; it requires change by all of us and tinkering in painless ways with the status quo will only build cynicism.

We need to understand each other better. Consumers must know that cost containment can impact quality and access to care. Providers need to feel the depth of business and public feeling about health care's consuming a greater and greater share of our economic resources. Public meetings, with media coverage, can illuminate the problem and lead to concrete action.

3. **The Blue Cross and Blue Shield Plan should develop and distribute data to the public and providers on health care costs to identify problems.** Blue Cross and Blue Shield of Georgia/Atlanta has a reservoir of data on costs and utilization patterns by physicians, hospitals, and patients, which can help define problems and point the way toward specific corrective actions. We need to look at the incredible variation in charges and costs for comparable services between providers and determine if they are justifiable.

Visibility of a broader range of data can be a major force for progress.

4. **Health planning must be encouraged.** There is overwhelming evidence that the Atlanta area is vastly overbedded. The capital and continuing operating expense associated with this are an enormous burden. Market forces, such as competition, work poorly in health care for a variety of reasons. Effective institution and areawide planning can lead to more effective use of scarce capital in the future and perhaps redeployment of current excess facilities into alternate uses.

Commitment

The cost problem will never be fully solved; health costs will continue to increase in the years ahead. The public will always resent the necessity of paying for services which, if they had a choice, they would not buy. But we must all recognize that there is much to be done and much room for improvement and get about the job in a credible way that the public can accept.

We need not be defensive about this. The cost problem ironically is the result of considerable success in health. Government has broadened access through Medicare and Medicaid programs and improved care through the vigorous National Institute of Health's varied research effort. Dedicated physicians continue to specialize, develop new techniques and provide a consistently high quality, complex service to a vast, heterogenous population that is demanding (and mostly getting) what it wants. Third parties cover more people with broader benefits than ever before.

Change is in order but not revolution. Needed is a consolidation of our considerable achievements and a new balance of our attitude and concerns, with economy given more priority. Our entire economy faces similar challenges; we are not alone. The auto industry, utilities, oil, education, and numerous others face pressures and challenges to do more with less. All are responding. Can we do less? Let's get our forces organized and get on with it!

A hospital administrator's prospective on the cost problem.

The Anatomy of Hospital Costs

W. DANIEL BARKER, F.A.C.H.A., *Atlanta**

CRIES FOR COST containment or cost control in the health care industry are being shouted by an increasing number of disgruntled, discouraged, and, in many cases, deceived consumers, payers and public servants. These cries reflect the overwhelming evidence that documents the dramatic increase in the cost ot medical care during the past two decades.

The unrelenting health care cost spiral has transferred a substantial proportion of our nation's productive capacity to the health care industry. For example, the proportion of our Gross National Product spent on health care increased from 4.6 percent in 1955 to 8.6 percent in 1976. The final result is a relatively smaller market basket of other goods and services available for the American consumer.

Bombardment with all sorts of statistics depicting the rise of health care costs have become routine for most of us in the health care industry. We live in a computerized data processing age where mountains of statistics can be generated almost at will. Perhaps many of us have become shellshocked with the barrage.

The statistics have told us everything about health care costs—except what we need to know. We know the What, How and When of health care cost inflation. Unfortunately, we still do not have a universally accepted solution for cost control.

* Administrator, The Crawford W. Long Memorial Hospital of Emory University, a division of the Woodruff Medical Center, 35 Linden Ave., NE, Atlanta 30308.

Until cost pressures in the health care indusry abate, cost containment will continue as the industry's most important policy issue. Solutions for cost control are critical, but they must be soundly based. Too often crisis conditions lead to political rhetoric which suddenly becomes legislation.

Because hospitals receive approximately 63 percent of all public health care expenditures and 34 percent of private health care expenditures, we find that we are in the forefront of criticisms regarding our present high cost situation.

The table below highlights a few statistics which summarize the hospital cost situation in Georgia and compares these figures for the last three years which are available with national averages. Except for the number of personnel per 100 patients, hospitals in Georgia rank considerably below the national average as far as cost per patient day, average annual salary, average length of stay and cost per admission. It is also significant to note that our rate of increase in Georgia is more rapid, percentage-wise, than for the nation as a whole.

What are some of the causes of these cost increases? Hospitals are not immune to higher consumer prices. Last year's budget does not stretch any further in a hospital than it does in your home or office. And the only way for hospitals to make ends meet, unfortunately, is to increase their only source of income: charges to patients.

In 1975 (the latest year for which detailed satistics are available), inflation was the single biggest influence on hospital costs. About 45 percent of the increase in charges was directly caused by price increases in the general economy. Because of the impact of inflation on hospital costs, it may be helpful to examine inflation in some detail. *Inflation* is a term which describes a period during which the price level for services and factors of production is generally rising. It is simply a descriptive term which is not intended to convey any explanation of the reasons for the rising prices.

Economists have defined two basic kinds of inflation: *Demand-pull inflation* arises when an insufficient supply of a good or service is increasingly desired by consumers, and prices are driven up by competition to meet these demands, *cost-push inflation* occurs when the prices of factors of production increase. The manufacturer or provider must raise his charges to consumers for the finished product to cover the higher costs he incurs in producing the product or service. From World War II until about 1970, charges for hospital and health care services increased because of the growing demand for health care. This experience corresponded to the economists' demand-pull inflation. The public's demand for such services grew faster than the industry could provide them. Greater health insurance coverage and a rising standard of living contributed to the growing demand for health care services, and that increased demand resulted in increased charges for hospital services averaging 9-11 percent per year between 1950 and 1967. After the implementation of Medicare and Medicaid, demand was augmented by the removal of many of the financial barriers to care for the aged and poor. Between 1967 and 1970, the average rate of increase in hospital charges was about 17 percent. Although this rate of increase was considerably greater than during the earlier period, the cause was the same—a growing demand outstripped the supply.

The rate of increase in the cost to the consumer of hospital services as measured by conventional indices had begun to abate by 1971 when wage and price controls were instituted throughout the economy. The hospital industry was the last from which these controls were lifted, in April, 1974. Because hospital charges were tightly controlled during this period, hospitals were restricted in their ability to pass on to consumers the higher prices they had to pay for the goods and services they purchased. Thus, when controls were finally lifted, hospitals were forced to "catch up" to the rest of the economy by raising their charges to cover, for example, higher wages. In 1974 and especially in 1975, the prices of the inputs (goods and services purchased) necessary for hospitals to provide their services increased at a rate more than 150 percent higher than the goods and services represented in the Consumer Price Index. The recent increase in the price of malpractice insurance, fuel, and household and maintenance costs have had an especially severe impact on the prices for hospital services.

The components of inflation can be analyzed in several ways. One way is to examine the pattern of hospital purchases over a period of time. The chart on page 300 compares these purchases in 1969 and 1975. In 1969, over 65 percent of the increase in hospital purchases over a period of time. The chart on page 300 compares these purchases in 1969 and vices, and labor inputs purchased. In 1975, increased prices or *inflation* was responsible for over 73 percent of the increase in this statistic (cost of goods and services plus wages). In 1969, hospital prices rose

SELECTED GEORGIA AND NATIONAL COMPARISONS FOR YEARS 1973, 1974, 1975

	1973	1974	1975	Percent Change
Cost per patient day				
Georgia	$ 88.95	$102.82	$122.14	+37.3
Nation	102.44	113.55	133.81	+30.6
Personnel per 100 patients				
Georgia	291	303	312	+ 7.2
Nation	282	290	300	+ 6.4
Average annual salary				
Georgia	$6,134	$6,725	$7,350	+19.8
Nation	7,368	7,787	8,635	+17.2
Average length of stay				
Georgia	6.7	6.6	6.4	− 4.7
Nation	7.8	7.8	7.7	− 1.3
Cost per admission				
Georgia	$596	$679	$ 782	+31.2
Nation	799	886	1,030	+29.9

Source: Hospital Statistics, American Hospital Association.

because hospital services were in great demand, and additional quantities of materials and personnel had to be purchased to provide them. By 1975, the demand for hospital service was no longer increasing at such a rate, but the general economy-wide increase in prices—combined with the prolonged periods of economic controls—forced hospitals to pay an increasingly greater amount for the inputs required to sustain even current levels of service. This threatened the long-range survival of many hospitals which had to borrow or deplete their endowment to meet current financial needs.

The prospects for a steadily increasing demand for hospital-related health care on the order of that prevailing during the 1950s and 1960s until the passage of Medicare and Medicaid has not been diminished by the prolonged period of inflation. Charges for hospital services are likely to increase at a less rapid rate in the future due to the gradual diminution of the influence of ESP on hospital finances. Nonetheless, the charges for hospital service may continue to rise above the rate of the Consumer Price Index because of the continuing demand for the most technologically advanced and readily accessible health care.

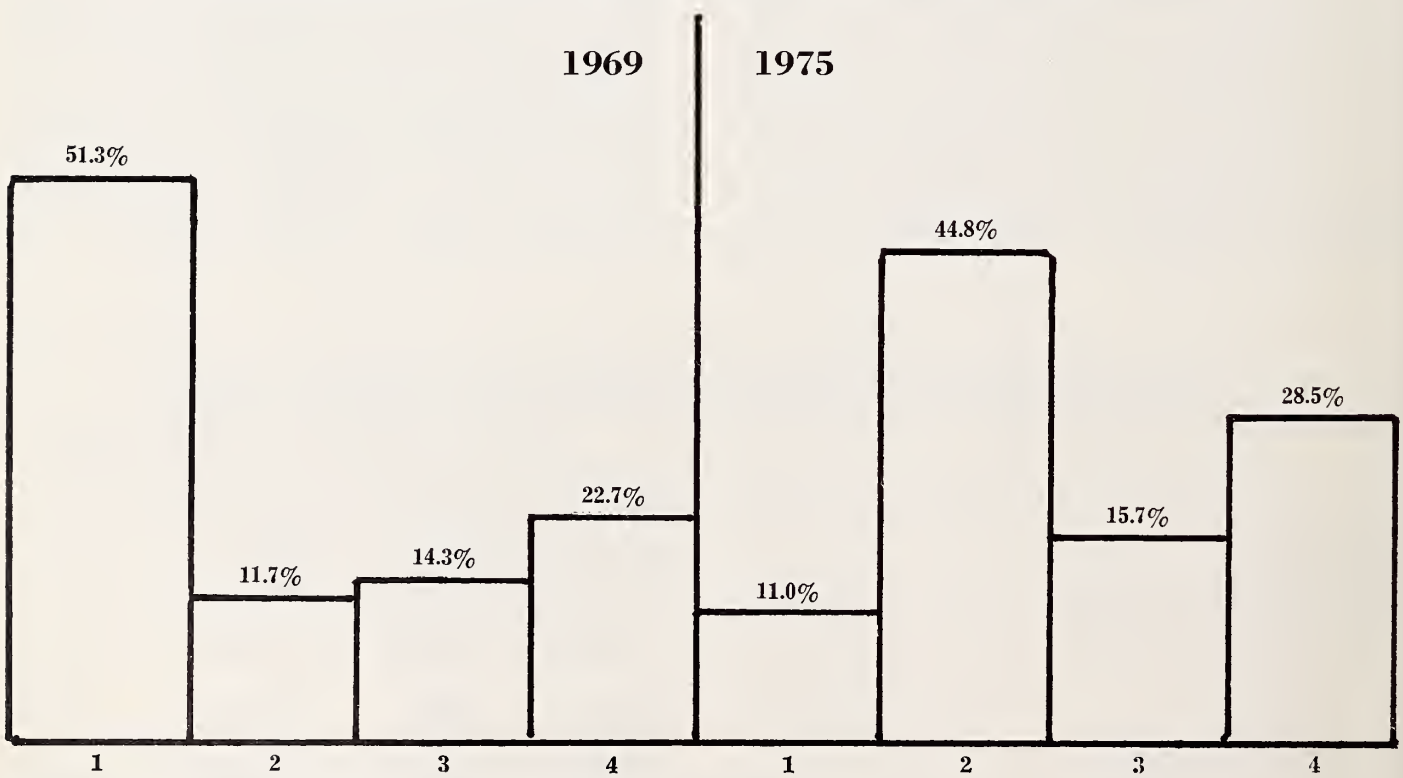
Where does inflation hit hospitals the hardest? In many of the same areas it hits your pocketbook: food, household items, heating and electricity. The cost of soaps and detergents purchased by hospitals have increased 21 percent in the last year, sheets are up 9 percent, the costs for electricity are 15 percent higher, and natural gas costs nearly 40 percent more than last year. The most dramatic change is the 200 percent increase in the cost of malpractice insurance.

As hospital administrators, we try to economize wherever possible, but we cannot influence the overall trend of spiraling costs due to inflation. Because of this, it is important that hospital administrations and medical staffs work together to control those elements of cost over which we have some influence.

In 1975, at its annual meeting, the Georgia Hospital Association unanimously passed a resolution "urging each of its member institutions to establish committees or other appropriate organizational structures, as a means whereby Trustees, Medical Staff Members, Administrators, Department Heads, and other employees may more effectively intensify their activities in the area of cost containment and productivity."

Such a committee was established at The Crawford

COMPONENTS OF TOTAL HOSPITAL INFLATION, 1969 AND 1975, BY PERCENT



KEY: 1—Increases in the quantity of goods and services purchased
2—Increases in the cost of goods and services purchased
3—Increases in the quantity of personnel employed
4—Increases in average wages

(Source: The Hospital Economy, 1975, Division of Information Services, American Hospital Association, 1976.)

W. Long Memorial Hospital of Emory University and some of our areas of activity to date are:

1. Included as a part of our regular medical audits a review of the hospital charges associated with the disease entity being audited. We have found that the range of cost for most episodes of illness studied to date is approximately 200 percent. When analyzed by physicians, we find that the range is much smaller and the variance is closer to plus or minus 20 percent.

2. We have analyzed cost per admission by discharge diagnosis with a comparable diagnosis for the prior year. In those instances where the cost has increased more than the Consumer Price Index, special studies are being instituted to try to discover the reasons for the higher cost.

3. We have analyzed the 20 most common causes for admission and developed detailed profiles of the services rendered these patients. These studies are analyzed on the basis of the date of admission, the attending physician, the age of the patient, and the distance the patient lives from the hospital.

4. Quarterly conferences with members of the medical staff in which itemized bills of selected patients treated by them during the last quarter are summarized and given to the physician so that he would have some idea of the cost involved in the treatment rendered.

5. We are in the process of instituting an on-line computer ordering system. One of the programs involved in this system will let the physician know the price for each service, test or procedure which he is ordering.

6. The above is just a partial list of some of our internal activities designed to keep the medical staff informed as far as costs are concerned.

Most of us will agree that we cannot put a price tag on health. When we are sick, we want to get well—whatever the cost. New technologies, new diagnostic procedures, monitoring systems, and surgical advances make possible a level of care undreamed of just a few decades ago. Technologies like these and the personnel who have been trained to apply them, do raise hospital charges. In many cases, high hospital charges are the price which we all must pay for up-to-date health care. But some of the cost of health care could be lowered and that is the purpose of our Cost Containment Committee.

In all of the discussion which is now taking place about health care cost, it is important that we always remember that the most important cost to be avoided in a hospital is the cost of human life.

CARTER HOSPITAL CONTROL PLAN LABELED THREAT TO PATIENTS

The Carter Administration's hospital cost containment proposal, announced April 25, is viewed as "unrealistic and a threat to the quality of patient care in our nation's hospitals" by Michael D. Bromberg, director of the Federation of American Hospitals (FAH), representing investor-owned hospitals.

According to Bromberg, the Carter plan calls for singling out hospitals and imposing a ceiling on them, while allowing all other sectors of the economy to go unchecked.

"Such a proposal is unfair and arbitrary," Bromberg said, "and it will not work. Not only is it impossible to inhibit inflation by law, but there is a real danger that by legislating a ceiling on hospital costs, the Administration would be directing hospitals to cut back on the quality of health care delivery," he explained.

Calling the Carter program "nothing more than a camouflaged version of the Nixon Phase IV controls," Bromberg urged Congress to reject it. "Our representatives should attack the problem of escalating health care costs 'head on' by legislating an end to the primary cause of inflation—cost reimbursement for hospitals."

FAH advises prompt action on a Medicare/Medicaid reform bill, to be introduced shortly by Senator Herman Talmadge, chairman of the Subcommittee on Health of the Senate Finance Committee. "That bill provides for an incentive payment system offering economic rewards for efficiency," Bromberg said.

"That would be the most effective and equitable means of containing health care costs, a goal shared by the Carter Administration and those of us involved in the delivery of health care," he continued. "Together with strengthened health planning and peer review, it is the fairest approach."

GOVERNMENT INVOLVEMENT IN HEALTH CARE BENEFITS NONE, SAYS NOBEL PRIZE WINNER

The present trend toward ever greater government involvement in health care is against the interests of patients, physicians, and hospital personnel, according to Milton Friedman, Ph.D., noted economist and distinguished University of Chicago professor.

Friedman delivered the keynote address, "The Economics of Healthcare," at the 11th annual Federation of American Hospitals' (FAH) convention in March.

The 1976 Nobel Prize winner in Economics believes that government involvement initially seems to serve the interests of at least hospitals and physicians by increasing expenditures on healthcare. "But this is a transitory phase, as the experience of other countries has demonstrated," he said.

"When government control becomes nearly complete, expenditures will shrink," Friedman continued. "Those sections of the health industry that have favored further government involvement are working against their own long-term interest."

This government official doesn't think government has to be the answer.

Wake Up, Doc!

DOUGLASS M. RICHARD, *Atlanta**

As a life-long practicing bureaucrat (GP, that is, not a specialist), I have available to me all the statistics one would need to fill up not just the space devoted to this one article but rather this entire issue. The things I could "prove" by use of these stats run the gamut from A to Z, and also from Z to A.

I could "prove" for example, that physicians are the cause of the horrendous annual increases in health care costs. I could also "prove" that physicians play no role whatsoever in those increases. I could "prove" that Medicare and Medicaid have been the primary contributors to the increases in health care costs over the past ten years. I could also "prove" they had a relatively insignificant part to play in that escalation. I could "prove" the whole country's going under if we don't get ourselves a national health insurance program, and soon. And, yes, I could also "prove" NHI's the last thing we need and would, in fact, have us bordering on the brink of bankruptcy very soon after it took effect.

In other words, I could "prove" just about anything I wanted to by strewing around *selected* statistics which, in and of themselves, would actually *prove* nothing. What's really frightening about all this is that it happens all the time. And you and I latch on to those statistics that appeal to us without really looking behind them, without really being informed, without really recognizing that in and of themselves they prove little or nothing. So I'm going to indulge in a little editorial freedom here and, in the body of this presentation, use statistics sparingly if at all.

What, then, does a bureaucrat write about if he can't spew out ominous statistics. Well, he can always prognosticate the future. That's pretty safe, because by the time the prognosticated events come (or do not come) to pass, few readers will remember what he said and practically none of those who remember will care. One in my position can't very well deal in "policy." I'm an administrative officer, not a policy officer. And I've said more than once (three times, in fact!) that in the government an administrative officer is to policy as a eunuch is to sex. (And that, I submit, ought to clarify that little detail!)

* Regional Medicare Director, Bureau of Health Insurance, Health Care Financing Administration, U.S. Department of HEW, 50 7th St., NE, Atlanta, Ga. 30323.

No, no stats, no policy. Just some thoughts developed over the past 4,213 days I've been involved (at this writing) in the Medicare program. None of that which follows is very profound, little of it is new, and much of it might not "set" very well, as we used to say down home in Savannah. But as Regional Medicare Director for the Southeast for 11 years, I've had an unusual vantage point from which to view the passing health scene. A vantage point, you say, that would tend to give one a distorted or biased view of things? Perhaps. But consider as well my credentials as a "consumer" of health care (a rather tortured bit of terminology, yet I know of no better way to put it). Given the fact I've a wife who's had two heart attacks in the last ten years plus other assorted ills, such as hypoglycemia, 11 hospitalizations in such diverse places as Atlanta and Johns Hopkins in Baltimore, with the accompanying expenses of insurance, costs above insurance, drug bills equaling if not exceeding physicians' costs—given all that, plus my own past-middle-age physiological creakings, groanings, and deterioration, you surely would agree the view isn't really all that slanted.

Speaking to the Florida Society of Internal Medicine during its annual meeting, I expressed one thought that quickly captured the wandering attention of that august group. I said to them (and I say it now to you, because I remain convinced of it to this day) that after working with and being subject to the ministrations of physicians over the years, I really believe the average practicing physician doesn't know what the hell is happening to him. I further said that if he doesn't begin to learn what's happening, if he doesn't begin to become involved in *causing* things to happen, he's going to look around one bright and shiny day and discover—to his great surprise and utter horror—that the practice of medicine is no longer what it once was (and what he wanted it always to be).

Oh, I'm not talking about those of you who are really involved in organized medicine, who are society officers, convention delegates, etc. I'm talking about the fellow who won't read his *Journal* because he's too busy, about the fellow who won't go to association or society meetings because they conflict in terms of time with hospital rounds, about the

fellow who doesn't know (and one wonders whether he would care if he did know) that there are hundreds upon hundreds of bills affecting his vocation and the way he practices that vocation submitted to the Congress each year. I repeat: I'm thoroughly convinced that poor guy doesn't know what the hell is happening to him. And that's sad. It's sad, too, that I read these journals much more thoroughly than do most physicians. It's sad, too, that in one city where there are about 3,700 physicians, the Medical Association can't muster a quorum at meeting after meeting. No, the poor guy doesn't know what's happening.

What has all this to do with the broad subject of health costs or health financing, to which I understand this issue of MAG's *Journal* is devoted? A great deal, I submit.

Where there is a void, it will be filled. And in the absence of action by the private sector, it will be filled by the government. There was a void, and we got Social Security. There was a void, and we got Medicare. There were voids, and we got Professional Standards Review Organizations, Health Systems Agencies, Program Review Teams, and a myriad of other governmental agencies and actions bearing on the health scene, on health care costs, among other things.

I'm not suggesting these things are bad, mind you. By the same token, I'm not suggesting they're good. I'm an administrative officer—remember the eunuch? What I *am* suggesting, though, is that each of these actions by the government would have been far better, both conceptually and in terms of implementation, had there been involvement to a much greater degree of practicing physicians—the people who really know with a real degree of certainty what it takes to render good health care and, conversely, what it *doesn't* take to do so. Had there been greater broad-scale involvement of practicing physicians in peer medical utilization (not fee) review, PSRO probably wouldn't ever have come ambling down the legislative pike. (And don't think you're going to "escape" PSRO just because you're in Georgia. It's coming. Inevitably, inexorably it's coming, either

"I'm thoroughly convinced that the poor guy doesn't know what the hell is happening to him."

under the aegis of organized medicine or under some other sponsorship.) Health Systems Agencies would still be a figment of someone's imagination had there been forceful, meaningful involvement of practicing physicians in local and area health planning.

And that all leads to another thought. If we really want to do something about health costs, we need to face up to a few things. Despite the pummeling physicians have received in recent years about costs, it's a fact that hospital costs in this country are approximately twice as large as physician costs. I don't know what percentage of hospital costs goes for personnel, but it's large, and it'll get larger. And there's nothing much we can hope to do about that. (As the husband of a registered nurse who served in hospitals for years, I've never really understood the logic that apparently assumes hospital personnel can buy groceries at the A&P on their good looks and therefore don't need wages equivalent to those of people in other professions.)

No, we can't do much about that, but something can and *must* be done about the *proliferation* of high-

"HSAs would still be a figment of someone's imagination had there been forceful, meaningful involvement of practicing physicians."

ly technical, extremely sophisticated, horribly expensive new equipment. CAT scanners come to mind. At $450,000 to $700,000 per scanner—those are very round figures—how much does a hospital add to each patient's cost per day when it purchases one? Easy now—I'm not suggesting that CAT scanners aren't just great, even though there still seems to be some division of opinion in the medical community about that. I'm simply suggesting that heavy physician involvement in the determination of *need* (as compared to prestigious desirability) of such items in a *given* hospital is badly, badly needed. You wonder if physicians can do anything about this? One small example: When an established, recognized and effective planning agency refuses, in effect, to permit hospital "X" to purchase a CAT scanner as unneeded, is the medical community serving the total community when physicians then band together to purchase one and set it up in the professional building next door to the hospital? I think not. Whatever became of peer pressure?

One could go on, but space doesn't permit. To sum up, it's my firm belief that because the average practicing physician doesn't know what the hell is happening to him, he isn't involved, he isn't influential, and he doesn't play the role he should and must in the overall health activities of this country. And because he doesn't, because he sits figuratively contemplating his navel while the whole scene changes around him, everything and everybody suffers, costs continue to shoot up, and the government of necessity continues to fill the void. And that's sad, because it doesn't have to be that way.

One final thought: I believe we've made it to this point without the use of statistical charts and columns of figures. Any time a bureaucrat can do that, there must be some hope for us left!

I've told this before . . .

(Editor's Note: In this story by Dr. McDaniel, a hunting guide's practical joke teaches him a lesson—or does it? Others wishing to contribute to this page shoud send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree Rd., NE, Atlanta, Ga. 30309.)*

Those Impish Little Devils

RECENTLY MY SON, GEORGE, who lives in Washington, D.C., invited his brother Stuart and me to participate in a goose hunt that he had arranged on the eastern shore of Maryland.

When we arrived at the motel in Chesterton, the lady that checked us in said that snow was predicted for the night. Sure enough, the prediction was correct; the next AM there was some five inches on the ground and big snowflakes were still falling.

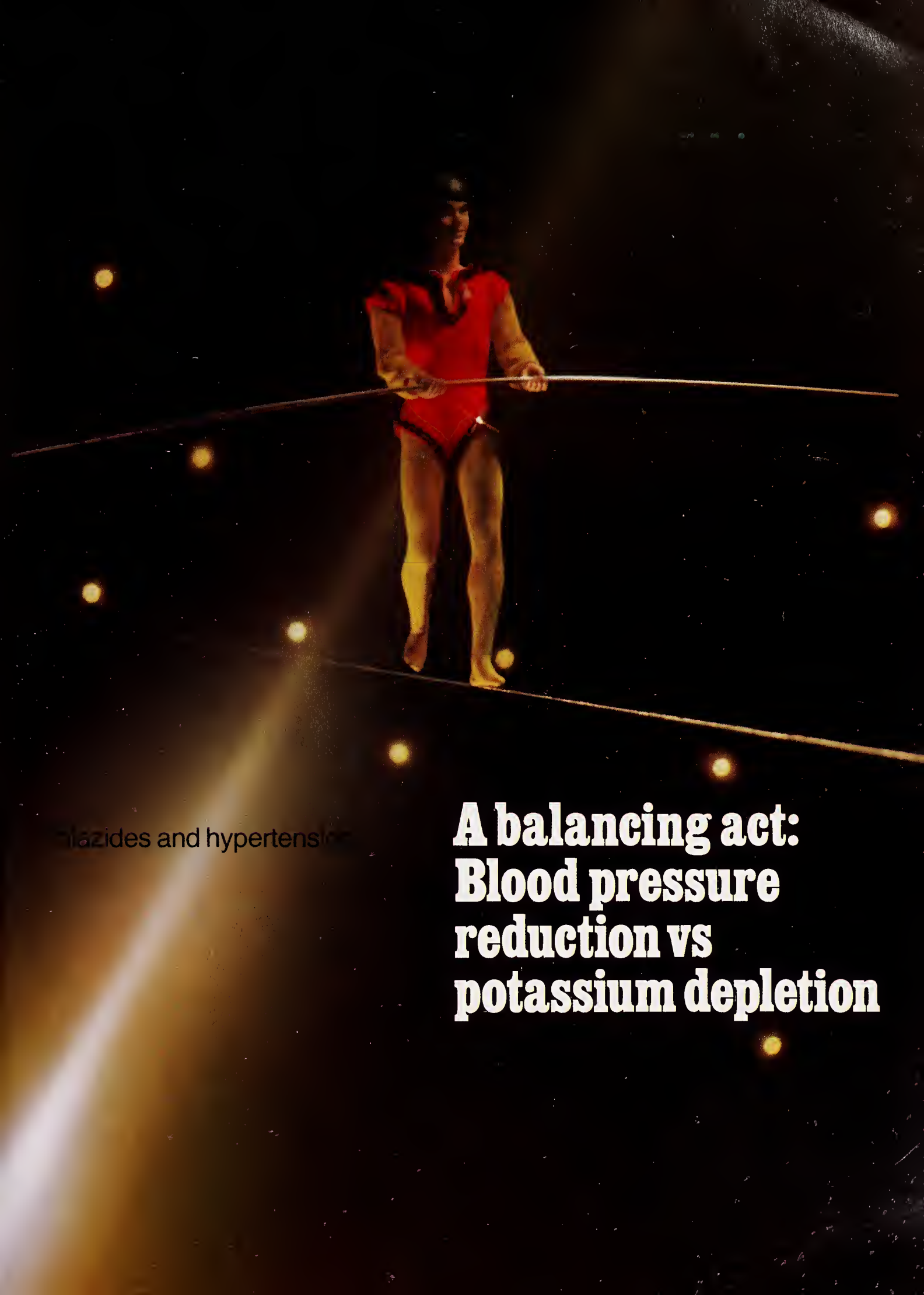
In the guide's truck, just past daybreak, we reached the blind safely, but it was still snowing. Our blind was an oblong pit dug out in a cornfield. About four feet deep, it had a long bench on one side and the top was covered with cornstalks flush with the gravel.

The outside world was silent as a tomb; no living thing was stirring or making any sound. The only thing that we could see was the snow-white field, the decoys and the gentle snowflakes. Our guide, an old man by the name of "Long" John, said that no respectable goose would fly until it had stopped snowing, and they didn't. He and I were about the same age and he sat me down, with freezing feet, beside him. It took little or no prodding to start him telling stories about hunting feats of long ago—and how things had changed in Maryland over the past 60 years. One story that he told and swore it to be true, I would like to pass on. I do not know how many more he would have told, had it not stopped snowing and the geese began to fly.

"Years ago," said Long John, "there was a guide down near Cox Creek who was pretty much of a character. He was a great practical joker and took particular delight in telling tall stories to amateur hunters. His name was Buck Chester. He was a good guide for both geese and fish and was much sought after.

"This particular weekend, a doctor from Baltimore had engaged him for deer hunting. The 'Doc' was a crack shot, a good hunter and quite persnickety; for example, the only deer he would shoot at had to be a young fat buck, and he preferred him to be running when he shot.

"When they started out in Buck's car a little after daylight, Buck said that he wanted to go by and see if an old Italian woman would let them hunt on her place. She was a sod widow, and old Joseph Bartole never did allow any hunting during his lifetime, but all the cows and hogs had now been sold and Buck had done her several small favors over the past year. Mrs. Bartole told Buck that it was all right for he and his friend to hunt there today, but first she wanted him to do her a favor. When Buck agreed, she pointed to a skinny old mule who was in an enclosure across the road. He had his head down and his forefeet spread apart to keep him from falling. 'I want you to go over there and shoot ole Ned,' she said. 'He's 35 or 40 years old, blind, his teeth are gone and he's so stove-up with rheumatism, he can't hardly walk. I'd shoot him, but I got the arthritis in my neck



azides and hypertens

A balancing act: Blood pressure reduction vs potassium depletion

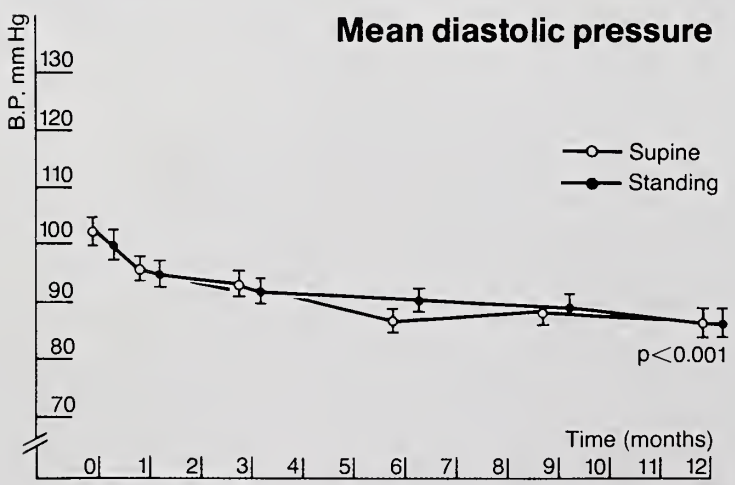
From a 1-year study of 18 patients with mild uncomplicated hypertension published in The Lancet*

Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

Diastolic blood pressure down 12-15%



"The mean pretreatment blood pressure was 170/103 mm Hg (supine) and 166/100 mm Hg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88 mm Hg (supine) and 142/88 mm Hg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762,1975.



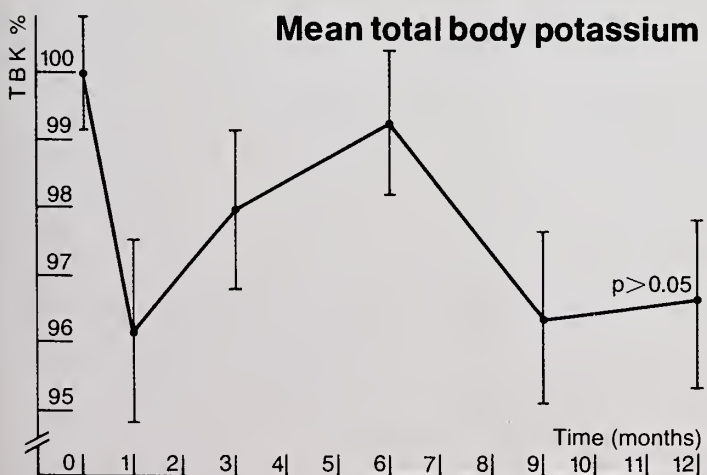
Once a day

Naturetin®

Bendro-flumethiazide Tablets N.F.

2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day
Naturetin®
Bendroflumethiazide Tablets N.F.

NATURETIN®-2.5
NATURETIN®-5
NATURETIN®-10
Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis. *Central Nervous System:* dizziness, vertigo, paresthesia, headache, and xanthopsia. *Hematologic:* leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia. *Dermatologic-Hypersensitivity:* purpura, photosensitivity, rash, urticaria, and necrotizing angiitis (vasculitis, cutaneous vasculitis). *Cardiovascular:* orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. *Other:* hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

SQUIBB®

©1977 E.R. Squibb & Sons, Inc. 477-501

and shoulders and Joseph's old gun kicks so hard, I'm afraid to. I called the vet, but he wants $5.00 for the trip—this man that rents a little patch from me said he'd bury him and I just can't stand to see ole Ned suffer any more. He was always a good mule.'

"The task was distasteful to Buck, but as he slowly walked back to the car, little devils began dancing and talking in his brain, as they had done so many times, and they formulated a little scheme to make the chore more palatable.

"When he got back to the car, he put a scowl on his face and said 'Doc, that ole biddy in there said that I could not hunt on her place as long as she lived, told me that I was a no good so and so and made my living by taking city slickers out to kill innocent birds, animals and fish, and when I reminded her of the goose I brought her last week, she told me in no uncertain terms what I could do with the next one instead of bringing it to her—she made me so mad that I could spit, I'm gonna get even with her, after all I've done for her. . . .'

"And with that he grabbed his old double barrel out of the back seat, loaded it with buckshot and said, 'I'm going over there and kill her damned mule, that'll cook her goose for now and always.'

"The Doc got out of the car and in his nicest bedside voice commenced with 'Now, Buck, let's just wait a minute, let's talk this thing over, we can find another place to hunt' and then after a few seconds, 'Now, Buck—haven't you got any damn sense—Buck—Buck—wait a minute!' The wire fence screeched as Buck went over it toward the mule.

"Buck walked up fairly close to the ole mule and shot him once, then waited a few minutes and shot him again, stood by about five minutes to be sure that old Ned would go to mule heaven where he could see, chew and romp with other mules and maybe even pull a golden chariot where the archangels would strum 'gee' and 'Har' and 'Whoa.'

"His chore finished, Buck walked back to the car, but the 'Doc' was not in evidence, nor were his gun, coat or shells. Mrs. Bartole said that as soon as the first shot was fired, he took off up the road toward the store. At the store, the storekeeper said that some man with a gun came in and gave Jim Peters $5.00 to drive him to the hotel. At the hotel, the proprieter said that 'Doc' had checked out about ten minutes ago and scratched off on the road to Baltimore. And naturally, Buck was left without the money for a three-day guide trip, due, of course, to the coy little devils that had caressed his brain.

"The story was told up and down Cox Creek and in Kent County. This taught Buck Chester a lesson. He drastically changed his ways. From then on he required that all guided tours, conducted by him, must be paid for in advance, for he knew and everybody else knew, that he would always listen to the siren songs of the impish little devils that sometimes danced in his brain."

J. G. McDaniel, M.D.
820 W. Wesley Rd., N.W.
Atlanta, Ga. 30327



METROPOLITAN PSYCHIATRIC

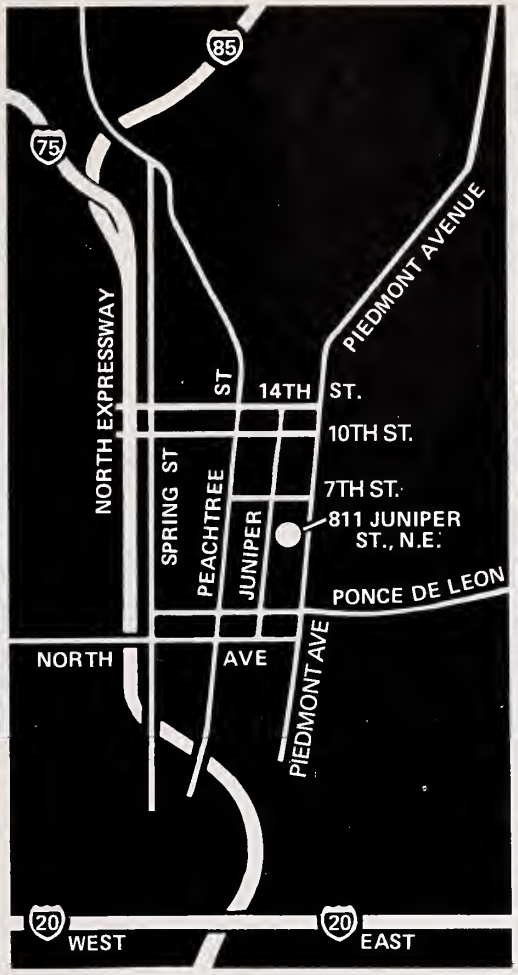
METROPOLITAN PSYCHIATRIC CENTER, centra
located in midtown Atlanta, provides comprehensive
services for adult and adolescent patients in the areas
psychiatry and alcohol and drugs. Inpatient care, out
patient care and partial hospitalization programs are
available at the Center.

In the Psychiatric Program, the attending psychiatrist
determines from the comprehensive services availab
the most appropriate modality(s) of treatment, but
always within the theme of individualized care.

The following services are available through the
psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

Family Counseling
Psychological Testing
Social Work Services
Educational Tutoring
Vocational Rehabilitation Counseling
Full Radiology Services
Activity Therapy Programs including Occupational Therapy, Recreational Therapy and Art Therapy

The Metropolitan Alcohol and Drug Program, directed toward recovery, offers a structured, comprehensive approach to the treatment of the physical, psychological, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

Ross Grumet, M.D.
Medical Director

Custis L. Rosser, M.H.A.
Administrator

Metropolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
811 Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

editorials
editorials
editorials

Responsible Restraint—A Key to Cost Control

PERHAPS PHYSICIANS should all be put on the public payroll. Perhaps each doctor should have to accept a certain number of Medicare and Medicaid patients in order to retain hospital privileges.

At least a ceiling should be placed on physicians' fees and hospitals expenditures should be limited to a 9% increase per year—regardless of the rate of rise of expenses.

Ideas such as these—as unworkable as they may sound—have been receiving prominent play in the press and on radio and T.V. Suggestions such as these have been given lip service by such influential persons as legislators, editors, Ralph Nader committeemen and the President of the United States.

These arbitrary ideas largely ignore the basic mechanisms underlying increased health costs. Increased costs throughout our economy are but a reflection of the general inflation perpetrated by increased deficit budgeting in our government. Only responsible restraint by the people we send to Washington to represent us can begin to halt this trend. The politician who promises the uniformed citizen more services from his government without apprising him of the economic consequences of deficit spending and spiraling inflation can only be guilty of a cruel hoax against the American people in order to perpetuate himself in office. The future of our economy is jeopardized by these "free lunch counter" pitchmen.

There is a well-recognized, increasing demand for utilization of pre-paid medical insurance. This urge seems to stem from such logic as "If I've paid for it I want to use it" or "I've paid into Social Security all these years and I deserve it." These attitudes are particularly crucial in a hospital environment where increasingly sophisticated, expensive, and well-publicized diagnostic tools are becoming available. Increased malpractice suits with their escalating influence on medical costs through the practice of defensive medicine constitutes a significant factor. Responsible restraint on the part of the physician in situations like this can help to hold the lid on costs. It is hoped that more reliance on sound clinical judgment rather than blind faith in machines may become more acceptable to patients.

Perhaps an effective deductible clause in all medical insurance—including Medicare and Medicaid—would promote responsible restraint among patients in the use of their prepaid medical benefits. Each consumer of medical care could better identify with the cost element inherent in any needed and valuable service. It would go far to dispel the "something for nothing" illusion for everyone. This would also tend to promote responsible restraint among that minority of physicians who tend to hospitalize patients for relatively minor complaints.

We are fortunate to have in this special-subject issue of the *Journal* some positive recommendations from authors representing the medical profession, hospital administration, insurance carriers and the federal government. With the information gleaned from these papers we should be better prepared to discuss these factors intelligently with our patients and ultimately to help formulate plans for more effective cost control. Your elected representative in Washington also needs your counsel.

Give us your thoughts.

Edgar Woody Jr., M.D.
Editor

High Blood Pressure Month: Treatment Is the Theme

MAY IS NATIONAL High Blood Pressure Month.

In Georgia, the observance is coordinated by the Georgia Heart Association and the Georgia Department of Human Resources, with most of the activity taking place at the local level through the efforts of committees composed of representatives of the Heart Association, health department and local medical, business and civic groups.

The stated objective of High Blood Pressure Month this year is: to increase the number of aware hypertensives who begin, maintain or resume adequate treatment for the control of high blood pressure.

Although emphasis is on treatment, this does not mean that efforts in screening or detection will be minimized or discontinued. These efforts are important. The number of people who have been found to be hypertensive has increased greatly, and so has the number of people who are adequately controlling their disease.

But statistics show that the "controlled" group is not increasing at the same rate as the number detected. Several million hypertensive Americans, in fact, are unsuccessful in controlling their disease. *And control is the key to saving lives.*

There are a number of reasons why so many hypertensives are not under treatment. These include:

1. Lack of understanding of the disease and its consequences.
2. Patient does not feel ill and therefore does not believe she/he has the problem.
3. Patient attitudes toward health and illness.
4. Failure to understand the need for life-long treatment.
5. Failure to take medication as prescribed; inability to remember details.
6. Side-effects of medication and lack of reporting such side-effects.
7. Failure to keep physician appointments for treatment evaluation.
8. Possibly, cost of medication.
9. Confusion regarding the term "hypertension" and "high blood pressure."
10. Inadequate or insufficient communication between treatment personnel and patient and families regarding the illness.
11. Lack of family cooperation in the treatment program due to lack of involvement and understanding.
12. Lack of or insufficient community resources to assist with the treatment program, such as dietary counseling, weight reduction programs, smoking cessation and prevention programs.

13. Lack of accessibility of medical care.
14. Inconvenience of obtaining medical care in terms of clinic hours, physician office hours, waiting time, etc.
15. Cost of medical care and other economic and social factors.
16. Language barriers or educational barriers to understanding of the terms used in counseling or instruction.

The course of action is clear. We must:

1. Increase our efforts to help the public understand the meaning and significance of hypertension.
2. Provide more individual instruction or counseling of screenees with suspected high blood pressure at the time of screening to encourage them to seek medical diagnosis.
3. Intensify our referral and follow-up methods to increase the number of individuals who report to a source of medical care for diagnosis.
4. Pay greater attention to those patients who are "repeaters" at screening programs but are not controlled.
5. Educate and motivate the hypertensive to stay on treatment—today and everyday.

Joseph A. Wilber, M.D.
President, Georgia Heart Association
Supervisor, Adult Health Section
Georgia Department of Human Resources
300 Interstate North
Atlanta, Ga. 30339

THE IMPAIRED PHYSICIANS CONFERENCE

On February 4-6, 1977, the American Medical Association, in conjunction with the Medical Association of Georgia, held the second national Conference on the Disabled Doctor at the Hyatt Regency Hotel in Atlanta. The conference, entitled "The Impaired Physician: Answering the Challenge," was opened by a welcoming speech from Richard E. Palmer, M.D., President of the American Medical Association. Then a talk and greeting was given by Earnest C. Atkins, M.D., Secretary of the Medical Association of Georgia.

For two days, a variety of topics relating to the impaired physician were explored by almost 300 concerned health professionals from all over the United States and Canada. Conferences included casefinding problems, the physician and his family, treatment techniques for both chemically dependent doctors and the mentally ill physician, economic readjustments, medical students, etc.

A highlight of the program was the Saturday luncheon presentation entitled "Recovery." Presentation of the Georgia plan was made, chaired by Dr. G. Douglas Talbott, Program Chairman of the Disabled Doctors Program of the Medical Association of Georgia. This was followed by four physicians who had recovered under the auspices of the Georgia plan.

Sunday workshop summaries were presented and a post-conference discussion was then held on the last day. This conference established Georgia's leadership in the field of the Disabled Doctors Program, by virtue of the Medical Association of Georgia's Plan. It brought national recognition to the Medical Association of Georgia's efforts in this health need of physicians.

—GDT

president's letter



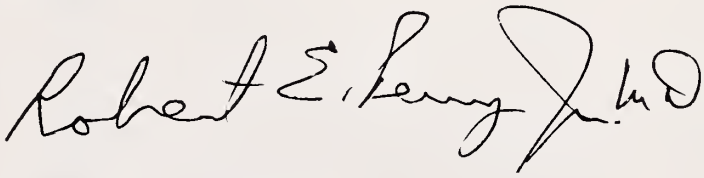
Quality Care Comes First

THIS MONTH'S *Journal* is devoted to "Health Care Costs." There is no doubt that there has been a tremendous increase in the total health cost; however, we must be cognizant of the fact that in all the government figures, there is general agreement that physicians' fees are less than twenty per cent of the total.

No accurate accounting of the administrative cost of the government's programs has ever been forthcoming. Perhaps its figures for administration are as distorted as the recent published list of physicians receiving more than $100,000 in the Medicare program. I would not be surprised if this were true.

It is my firm belief that each and every one of you continues your upmost to render quality patient care in the most economical fashion which you can. We should certainly strive to do this. It is my opinion that as the government becomes more and more involved in our professional activities, its overall expenditures are going to increase even more; however, this should not deter us from providing quality medical care for the benefit of our patients who rely upon our judgement in so many vital matters.

Sincerely,



Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia

Letters to the Editor

Speakers Bureau: Thumbs Up

Dear Sir:

Your editorial, "Why Not a Speakers Bureau?" in the March issue of the *Journal* makes more sense than any proposal I have seen in some time. It has become obvious that the only way we can effectively reach the lay public with "our story" is through personal contact as it does not reach them through the news media as it should.

If you would consider me acceptable, I should like to volunteer to help carry out this program, and it is my hope that other members of the Auxiliary throughout our state will join with me in this fine endeavor.

Sincerely,

Mrs. Milton F. Bryant, Jr.
Immediate Past President, Auxiliary to the
Medical Association of Georgia

Dear Sir:

I read with great interest the recent editorial in which you stated that you are interested in spreading the word to the public regarding medicine's contributions to the American health problems. Since I have spent a great deal of time attempting both by the spoken and written word to inform the badly misinformed public, I would be most interested in receiving any information or advice you might have.

I have also been interested in trying to formulate a statewide physician staffed information and publicity bureau.

Most sincerely,

C. B. Futch, M.D.

Dear Sir:

I read with great interest your article "Why Not a Speakers Bureau?" in the March issue of the *Journal*. As chairman of the Public Relations Committee of the DeKalb Medical Society, I would like to inform you that as of January 1977 our Society is currently involved with setting up such a speakers bureau. I certainly agree with you that if the American physician is not going to take his case to the public, then it is obvious that no one else is going to. Our Society has long been active in civic participation, and the Public Relations Committee has been very anxious to enter the field of providing physician speakers to different civic organizations. We are starting this bureau very slowly with only a core of perhaps ten to fifteen well groomed speakers. They will present selected topics to various organizations which request medical speakers through our Society. The Public Relations Committee has great hopes for the speakers bureau in terms of both excellent public relatoins and civic acceptance of, as you put it, "explaining the facts about medical cost to the American People."

I would greatly appreciate any information you might have in helping us begin this speakers bureau and, also, on the progress of your endeavors.

As public relations is probably our most vital interest in these times, our Society has established a "Doctor DeKalb" article in the *DeKalb News Sun* paper which is published bimonthly and gives us a forum for physicians to speak out on different medical socioeconomic topics. We have recently completed a Health Services Directory which is a guide of the health resources available in DeKalb County. We continue, in our Society, to be very interested in the involvement and public awareness of the medical profession.

Thank you for your time and especially in your endeavors as editor of our *Journal*.

Sincerely,

Andrew P. Morley, M.D., Chairman
Public Relations Committee
DeKalb Medical Society

Dear Sir:

I emphatically agree with your editorial in the March *Journal*.

I would be keenly interested in anticipating in any way possible to facilitate the speakers bureau to inform the public of the ripoff being perpetrated by the government with relation to doctors, as well as the public.

Sincerely yours,

Richard C. Mattison, M.D.

Dear Sir:

Your idea of having a Speaker Bureau to explain the high cost of medical care is appealing.

I am interested in having the facts at my disposal which you suggest are available through the Medical Association of Georgia. Whether these facts are available as such or through the talks prepared by the Medical Association of Georgia, I would appreciate receiving them.

I personally need to be better informed about the reasons for the high cost of medical care and will appreciate receiving this information you mentioned in your editorial (March 1977).

Sincerely yours,

William H. Moretz, M.D.
President, Medical College of Georgia

Dear Sir:

This letter is in regard to your recent editorial in the *Journal of the Medical Association of Georgia*. Needless to say, one can only agree that the medical profession has become somewhat of a scapegoat for media and various interest groups. Unfortunately, control of the media is much of the key to being able to sway public opinion and thus the political process. To retort with paid advertisements only comes across to the public as

self-serving and appears to be of limited benefit.

I wholeheartedly agree with you that a Speakers Bureau would be quite advantageous. Not only would it enable the public to become more fully informed, but the interchange of ideas and information and a open forum can only help the public to not only understand the problems involved in medicine but also the problems involved in a free enterprise system—a system of which medicine is a part and the system upon which our country was founded and upon which our country has flourished for the past 200 years.

Needless to say I would like to help you in this project and hope that you will be able to proceed with it and that I will be hearing from you in the near future.

HERBERT GOROD, M.D.
Center for Interpersonal Studies, P.A.

Why Get Involved?

Dear Sir:

The annual AMA Leadership Meeting is planned for state and county elected and executive officers of our organization. It is a complete overview of the issues we M.D.s have to be involved in regardless of the levels and spheres of our differing medical careers.

I became involved with these national meetings three years ago while I was a member of the Communication Committee MAG. That year the leading issues were P.S.R.O., national health insurance, the malpractice crisis.

This year there was a realistic evaluation of AMA as a lobbyist group and as a health provider. There were many Washingtarian bureaucrats around, and the atmosphere of the meeting was very serious and somewhat depressing. My once progressive, honorable and fair-shake-for-"all" philosophy had faded, but I still found myself at odds with AMA policy procedures.

Why all this meeting with Washington committees? Can't we just tell the "nation" that what we have in national health care is not all bad and that we do not need to completely overhaul it or replace it? We cannot. The politician and the public are on a march tuned to a drummer we cannot reach. The public will allow the bankruptcy of the country to provide themselves with the "right" of medical care.

The political figures at the meeting spoke with a forked tongue—"You doctors were doing a good job" *but* "You need more guidelines and controls." They added, "You are a generally most trusted lot, but we need to regulate you more."

Let's not hide behind phrases and platitudes like "cost containment" or "physician-patient relationship." Let's sit down together and plan. We don't have the money now but we will have to do something.

This meeting had an air of uncertainty about the future of organized medicine. So much of medicine remains un-organized. We need to keep our medical students and house officers very active and informed about political problems of medicine.

How can we get the physicians in the medical school faculties to join us in the AMA and quit being above it all? As I commented at the beginning of this letter, this was my third meeting and all I heard was talk. But I can assure you, my fellow members, I'm involved and plan to stay that way—so should you!

MARVYN D. COHEN, M.D.
1968 North Ave.
Columbus, Ga. 31901

Colonial
Leasing

Now leases all makes and models of cars

Now in stock for immediate delivery:

77 MERCEDES 300D

77 MERCEDES 240D

77 MERCEDES 450SL

77 LINCOLN MARK V

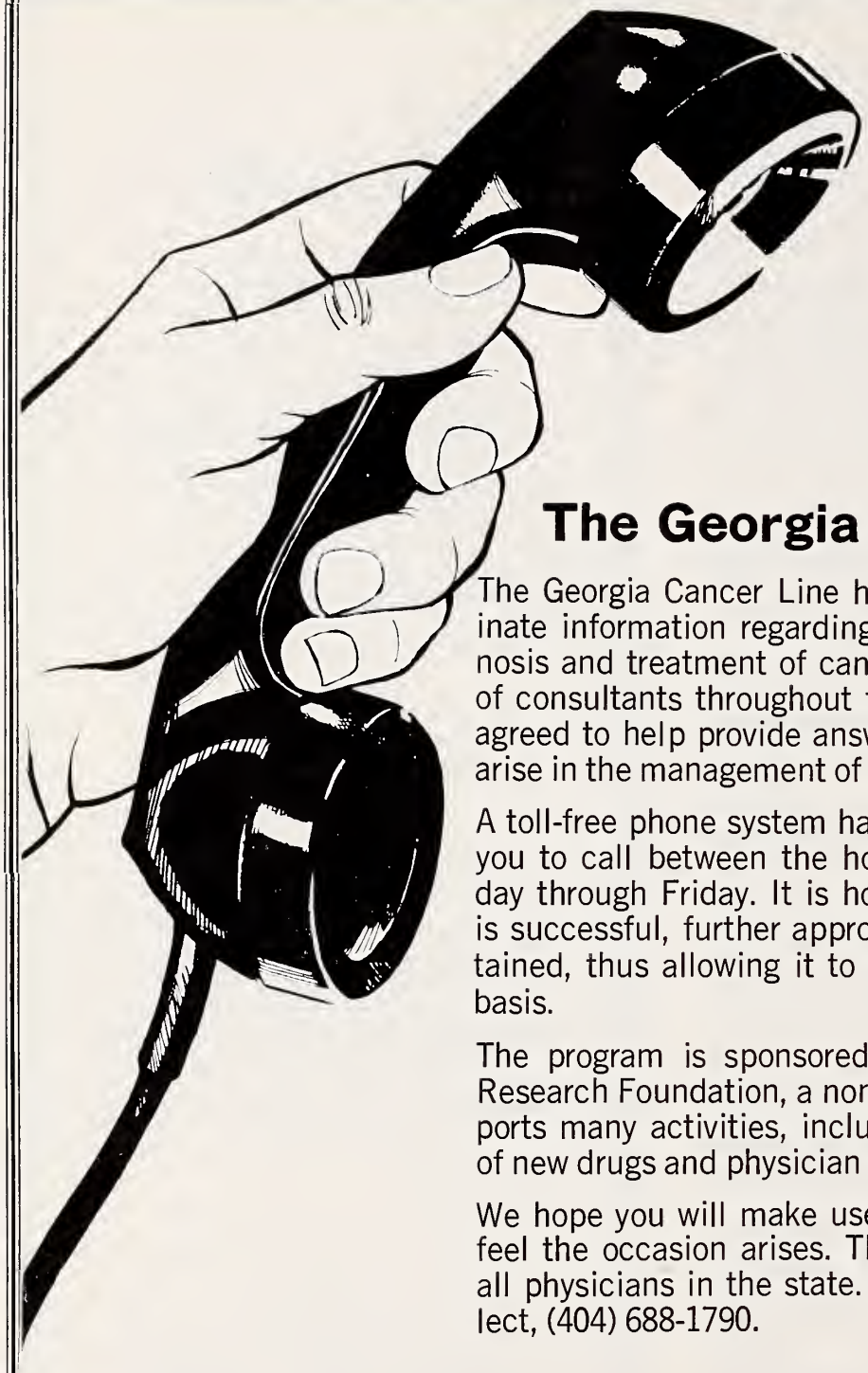
77 LINCOLN TOWN COUPE

Plus Many More Makes and Models

Call for rates on Walk-away Open-end or full-maintenance leases available

CALL 261-2820

Division of
Colonial Lincoln-Mercury
3167 Peachtree Rd.
Atlanta, Ga. 30305



The Georgia Cancer Line

The Georgia Cancer Line has been developed to disseminate information regarding recent advances in the diagnosis and treatment of cancer. We have enlisted a group of consultants throughout the state of Georgia who have agreed to help provide answers to questions which might arise in the management of cancer cases.

A toll-free phone system has been set up which will allow you to call between the hours of 9 am and 5 pm, Monday through Friday. It is hoped that if this pilot program is successful, further appropriate sponsorship can be obtained, thus allowing it to be continued on a permanent basis.

The program is sponsored by the Southeastern Cancer Research Foundation, a non-profit organization which supports many activities, including clinical research, testing of new drugs and physician education projects.

We hope you will make use of this system whenever you feel the occasion arises. The Cancer Line is available to all physicians in the state. All you have to do is call collect, (404) 688-1790.

Sponsored by
The Southeastern Cancer Research Foundation
P.O. Box 54777, Atlanta, Ga. 30308
(404) 688-1790

Call Collect

(404) 688-1790

Summary Statement from Workshop on Late Effects of Irradiation to the Head and Neck in Infancy and Childhood

(Because of increased public interest and inquiries on the "Late Effects of Irradiation to the Head and Neck in Infancy and Childhood," we are reproducing below a Summary Statement from the Workshop on this subject that has recently been published by the Division of Cancer Control and Rehabilitation of the National Cancer Institute. The complete report is to be sent to all primary-care physicians upon its receipt from the U. S. Department of Health, Education and Welfare.—**LaMar S. McGinnis, Jr., M.D., Chairman, Professional Education Committee, American Cancer Society, Georgia Division, Inc.)**

EXPOSURE OF the thyroid gland to external beam X-irradiation or to radium plaques during treatment of various nonmalignant conditions of the head, neck or upper thorax in infancy and childhood is now recognized as a possible cause of the development of both benign and malignant tumors of the thyroid many years later.

For several decades, beginning in the 1920's, radiation therapy was considered good medical practice and very effective treatment for patients with such conditions as enlargement of the thymus gland, hypertrophy of tonsils and adenoids, deafness due to hypertrophied lymphoid tissue around the Eustachian tubes, cervical adenitis, hemangiomas of the head and neck, tinea capitis and acne.

A linkage of thyroid tumors with prior irradiation was not recognized until these tumors began to be diagnosed with increasing frequency in individuals more than five years after the initial treatment.

It is now recognized that the effect continues into adult life, and that anyone with a history of such prior irradiation is at significantly increased risk of developing thyroid tumors. Intervals of more than 35 years between irradiation and diagnosis have now been recorded.

Fortunately, the tumors produced are generally slow-growing and benign. Even

---

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

when malignant, they usually remain confined to the neck for long periods and can be successfully removed surgically.

The greatest problem is to identify those individuals who actually received irradiation to the head or neck in childhood and should now be subjected to careful examination and continuing followup. Many individuals do not know whether or not they received such irradiation, and the records of treatment given so many years ago may no longer be available. Any hospital which has suitable records for tracing such patients is strongly encouraged to initiate a recall program, but in general, the best means of alerting the irradiated population will be a carefully planned public education program about the problem. Any individual who thinks he may have had such irradiation—as well as anyone who feels a lump in his thyroid gland—should be encouraged to visit his physician or usual source of medical care for an examination.

The most important part of the examination is the inspection and palpation of the thyroid gland. Tests of blood or other body fluids are not useful in the differentiation of benign from malignant nodules. There is some disagreement on the value of radioisotope scans, but many physicians consider them helpful, since "cold" nodules (i.e., those which do not accumulate radionuclide) are more likely to be carcinomas. A scan may also reveal a small lesion which cannot be detected by palpation.

A trial of thyroid hormone administration may be used to shrink the thyroid gland and thereby make palpation of a doubtful nodule more definite. Thyroid hormone may also be given in the treatment of diffuse enlargement of the thyroid. Some authorities consider it worthwhile to offer thyroid hormone to asymptomatic patients with a history of head or neck irradiation in the hope of preventing the development of thyroid tumors.

In general, surgical exploration should be considered for all palpable thyroid nodules, particularly those which are firm and clearly demarcated and those which are cold on scan.

All individuals who are at risk because of prior radiation to the head or neck and those who have already been treated surgically for a thyroid malignancy should be followed with regular re-examination every one or two years.*

---

* *A similar short statement has been prepared by the American Thyroid Association and distributed to its members.*

how do others avoid tax headaches? your CPA knows.



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

GEORGIA CPA SOCIETY

GEORGIA SOCIETY OF
CERTIFIED PUBLIC ACCOUNTANTS

4105A

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

WEIGHT WATCHERS

2639 North Decatur Road
Decatur, Georgia 30033

For class information in the Atlanta area call: 373-5731
Outside the Atlanta area dial free: 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1976-1977

Certification Exam For Physician's Assistants

The National Commission on Certification of Physician's Assistants has scheduled the 1977 Certifying Examination for Assistants to the Primary Care Physician for October 5, 6, 7, and 8. The deadline for receipt of applications is July 6, 1977.

Formal training programs will receive an ample supply of applications for their students directly from NCCPA.

For eligibility information and/or individual applications, write:

Registrar, NCCPA
Suite 560, 3384 Peachtree Rd., NE
Atlanta, Ga. 30326
Telephone: (404) 261-1261

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Administrator
Dennis P. Dobard

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

heart page
heart page
heart page

Vasodilators: an Advance in Management of Congestive Heart Failure

ARTHUR J. MERRILL JR., M.D., *Atlanta**

MOST PATIENTS with congestive failure respond to Digoxin or other digitalis preparations, salt restriction and diuretics no matter what the etiology of the failure. Diuretics, though controlling congestive symptoms, may even lower the cardiac output so that the patient complains of fatigue rather than shortness of breath. Other problems with potent diuretics are postural hypotension, hypokalemia and increased incidence of digitalis intoxication. For these reasons, other therapeutic agents would be helpful.

Since the 1940's, clinicians have known that blood pressure remains unchanged in congestive failure[1, 2] and that systemic vascular resistance increases, often out of proportion to the fall in cardiac output.[3] Venous pressure rises and venous resistance and distensibility decrease. These are probably reflex changes since all are reversed by improvement in the failure.

Vasodilators Improve Outlook

Utilizing this knowledge, Gould,[4] Chattergee[5] and others began to report the use of vasodilators in the management of failure in acute myocardial infarction. Cohn showed that left ventricular filling pressure, and thus probably cardiac output, could be controlled by changing systemic blood pressure in patients with myocardial infarction and congestive failure and/or shock.[6] Intravenous systemic vasodilators such as Phentolamine and Nitroprusside were shown to increase cardiac output as much as 40%.[7, 8] Nitrates, both PO and IV, have been shown to reduce left ventricular filling pressure, but their effect on cardiac output has been variable.[9-11] Recent studies have shown that the increase in cardiac output seen with the intravenous vasodilators is equally dramatic in chronic heart failure.[12] Mitral and aortic insuf-

* Associate Professor of Medicine, Cardiology, Emory University School of Medicine, The Carlyle Fraser Heart Center, Crawford W. Long Memorial Hospital, 25 Prescott St., N.E., Atlanta, Ga. 30308.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

ficiency are also markedly improved by Nitroprusside or Phentolamine,[13] so much so that patients may improve from pulmonary edema to asymptomatic with mild exercise.

In addition, oral nitrates (isosorbide dinitrate) in doses of 20 to 30 mg. every four hours have been shown to reduce congestion and occasionally also to reduce heart size when given chronically.[14] Their effect on cardiac output is controversial. These effects last 4-5 hours. Chattergee, et al.,[15] have just reported even more impressive results with the use of Hydralazine in doses of 50 to 75 mg. every six hours. Their patients were almost all class IV (dyspnea at rest) in spite of digitalis and 160 to 840 mg. of Lasix per day. Cardiac output rose 70% as systemic vascular resistance fell 42%. Arterial pressure fell only 5%. The clinical improvement in these patients was maintained for six months to one year. The author has now treated a number of patients with severe refractory failure using first Nitroprusside and then oral Apresoline with similar results.

Recommendations

For these reasons, the author's approach to congestive heart failure has changed and recommendations are as follows:

First the patient should have a period of bed rest, digoxin (or other digitalis preparation). If failure persists, first a mild diuretic, then furosemide up to 120 mg. as a single daily dose may be used. The single dose promotes a larger diuresis than the same amount of drug given in divided doses. Adequate potassium replacement with potassium chloride (not potassium gluconate or potassium bicarbonate) is very important and serum potassium is kept above 4 meq/L. Any hypertension must be vigorously treated, usually with hydralazine or alpha methyl dopa with the goal of therapy being a blood pressure of 120/80 without severe postural hypotension.

If the patient still has significant symptoms or has not lost weight, then isosorbide dinitrate is added, initially 10 mg. every four hours (or Nitrol Ointment, 1 inch every four hours). The dose is increased until the patient is taking 40 mg. every four hours (or three inches of Nitrol Ointment) or has some postural hypotension or intolerance of the nitrates.

If symptoms of congestion persist, then hydralazine is added to the regimen. Initially, 10 mg. every six hours is used, but as long as no postural symptoms occur, (these can often be prevented by lowering the nitrate dose slightly), the dose can be increased to 50 or even 75 mg. every six hours. If the blood pressure falls, then the filling pressure in the left ventricle must be monitored using a Swan Ganz pulmonary artery catheter before continuing the patient on therapy. Optimal left ventricular filling pressure is twelve to eighteen mm Hg in these patients. Presently, I hospitalize all patients who have severe enough failure to require treatment with hydralazine.

Results

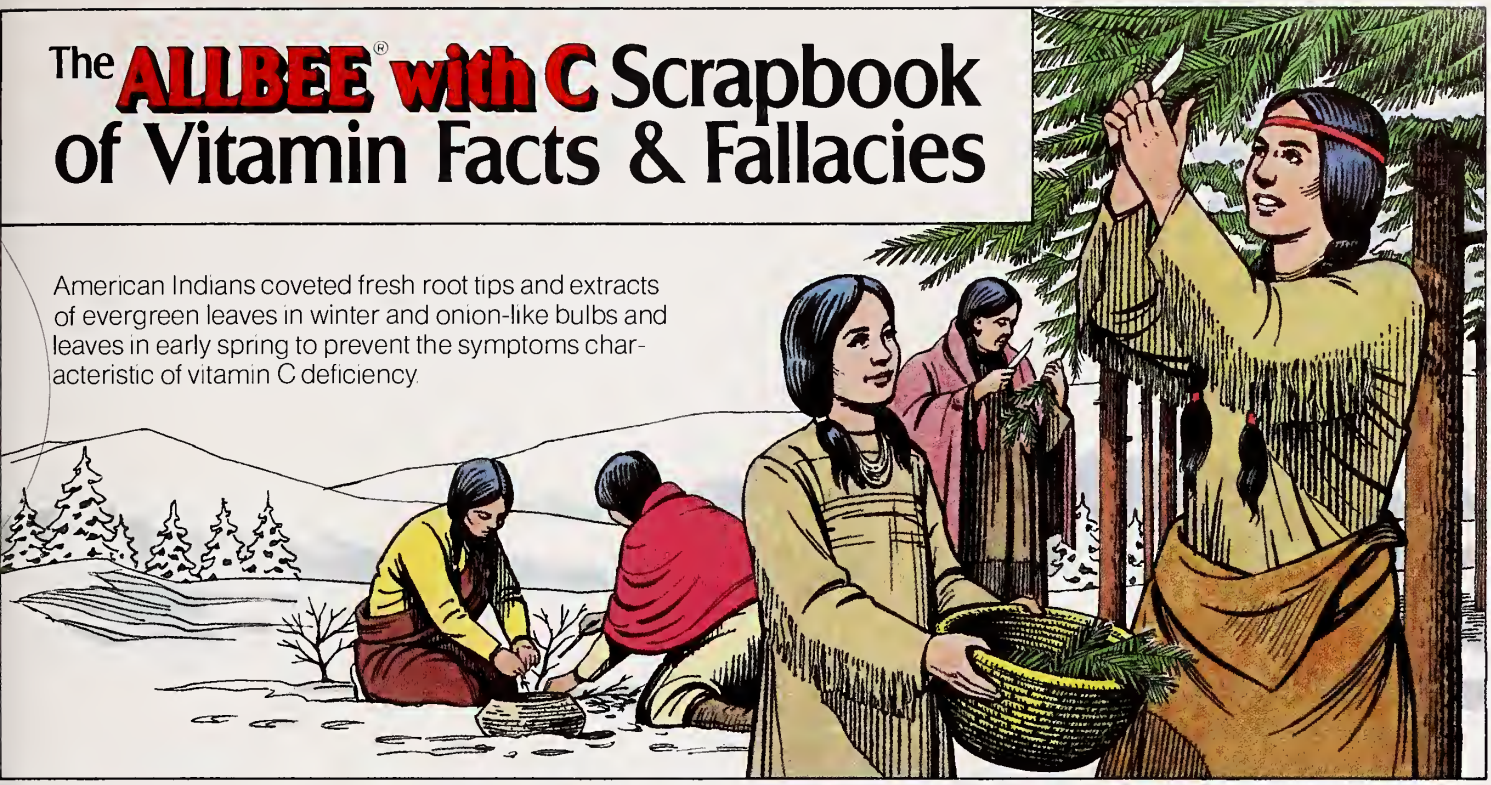
Symptoms and cardiac output improve quickly with vasodilators, but in the author's experience, the x-ray evidence of failure clears much more slowly and the patient may continue to lose weight for several weeks. Indeed, often the dose of diuretics can be decreased over the ensuing weeks.

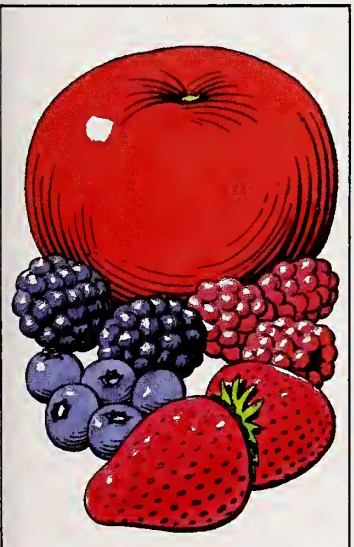
Obviously, patients with several enough failure to require this type of therapy have a poor long-term prognosis unless they have valvular lesions or aneurysms that can repaired surgically. They are much more comfortable and able to take care of themselves following vasodilator therapy. The hazards of hydralazine induced lupus must be watched for, but have not been reported thus far.

In conclusion, vasodilators are a very useful adjunct in chronic heart failure, particularly if it is refractory to conventional therapy. Usually the vasodilators can be given orally without monitoring cardiac output or left ventricular filling pressure if dosage is increased slowly and postural hypotension and/or tachycardia is avoided. This therapy is physiologically sound since peripheral resistance is high in conges-

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies

American Indians coveted fresh root tips and extracts of evergreen leaves in winter and onion-like bulbs and leaves in early spring to prevent the symptoms characteristic of vitamin C deficiency.

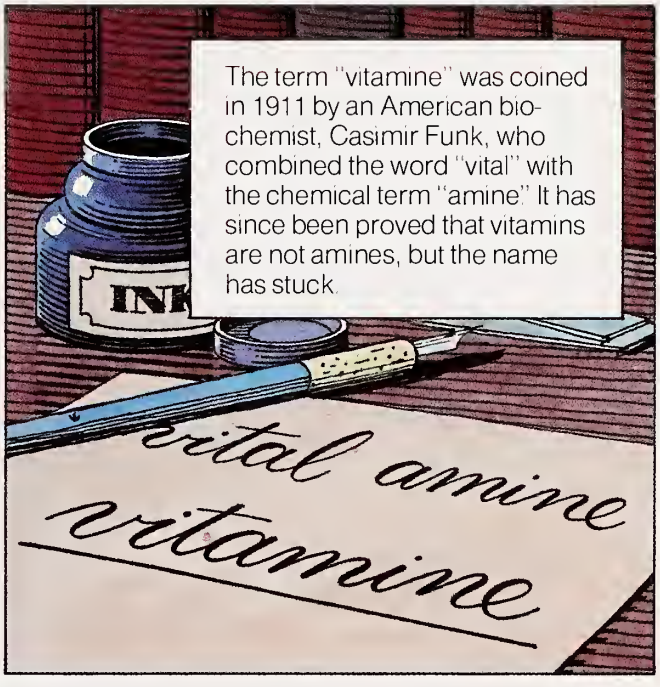




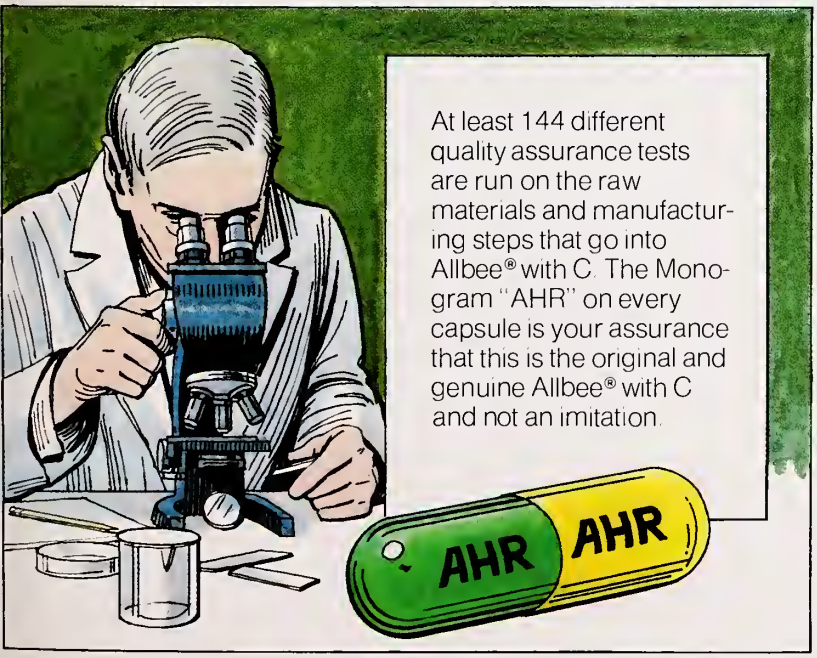
A tomato is botanically classified as a berry!



It is ironic that many of the vegetables highest in vitamin C and riboflavin are considered unappetizing by many people. These include turnip greens, kale, chard, mustard greens, spinach, water cress, broccoli and brussels sprouts.



The term "vitamine" was coined in 1911 by an American biochemist, Casimir Funk, who combined the word "vital" with the chemical term "amine." It has since been proved that vitamins are not amines, but the name has stuck.



At least 144 different quality assurance tests are run on the raw materials and manufacturing steps that go into Allbee® with C. The Monogram "AHR" on every capsule is your assurance that this is the original and genuine Allbee® with C and not an imitation.

Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 ml tsp of elixir (23% alcohol)	each Donnatal No. 2 Tablet
Phenobarbital (warning: may be habit forming)	(¼ gr) 16.2 mg	(½ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage..

A·H·ROBINS A. H. Robins Company, Richmond, Virginia 23220

tive failure and cardiac output goes up as resistance is lowered. For these reasons, the author has found vasodilators very helpful in the management of severe congestive heart failure.

BIBLIOGRAPHY

1. Myers, J. D. and Hickam, J. B.: "Estimation of hepatic blood flow and splanchnic oxygen consumption in heart failure," *J. Clin. Invest.* 27:620, 1948.
2. Rapaport, E., Weisbart, M. H. and Leirne, M.: "The splanchnic blood volume in congestive heart failure," *Circulation* 18:58, 1958.
3. Mason, D. T.: "Failure and blood flow in the forearm in clinical staff conference, congestive heart failure, biochemical and physiological considerations," *Ann. Int. Med.* 64:920, 1966.
4. Gould, L., Reddy, C. V. R., et al.: "Use of phentolamine in acute myocardial infarction," *Am. Heart J.* 88:144, 1974.
5. Chattergee, K. and Swan, H. J. C.: "Vasodilator therapy in acute myocardial infarction," *Mod. Concepts of Cardiovas. Dis.* 43:119, 1974.
6. Franciosa, J., Cruha, N. H., Cohn, J. N., et al.: "Arterial pressure as a determinant of left ventricular filling pressure after acute myocardial infarction," *Am. J. Cardiol.* 34:506, 1974.
7. Chattergee, K., Parinley, W. W., et al.: "Hemodynamic and metabolic responses to vasodilator therapy in acute myocardial infarction," *Circulation* 48:1183, 1973.
8. Miller, R. R., Vismara, L. A., et al.: "Clinical use of sodium nitroprusside in chronic ischemic heart disease," *Circulation* 51:328, 1975.
9. Flaherty, J. T., Reid, P. R., Kelly, D. T., et al.: "Intravenous nitroglycerin in acute myocardial infarction," *Circulation* 51:132, 1975.
10. Bussman, W. D., Lohner, J. and Kaltenbach, M.: "Orally administered isosorbide dinitrate in patients with and without left ventricular failure due to acute myocardial infarction," *Am. J. Cardiol.* 39:91, 1977.
11. Williams, D. O., Amsterdam, E. A. and Mason, D. T.: "Hemodynamic effects of nitroglycerin in acute myocardial infarction," *Circulation* 51:421, 1975.
12. Guiha, N. H., Gohn, J. N., Mikulic, E., et al.: "Treatment of refractory heart failure with infusion of nitroprusside," *New Eng. J. Med.* 291:587, 1974.
13. Goodman, D. J., Rossen, R. M., Holloway, E. L.: "Effect of nitroprusside on left ventricular dynamics in mitral regurgitation," *Circulation* 50:1025, 1974.
14. Franciosa, J. A., Mikulic, E. and Cohn, J. N.: "Hemodynamic effects of orally administered isosorbide dinitrate in patients with congestive heart failure," *Circulation* 50:1020, 1974.
15. Chattergee, K., Parmley, W. W., Massie, B., et al.: "Oral hydralazine therapy for chronic refractory heart failure," *Circulation* 54:879, 1976.

HOLTER MONITOR FREE

HAVE YOUR OWN AVIONICS HOLTER TWO CHANNEL RECORDER IN YOUR OFFICE FREE THROUGH USE OF OUR SERVICE.

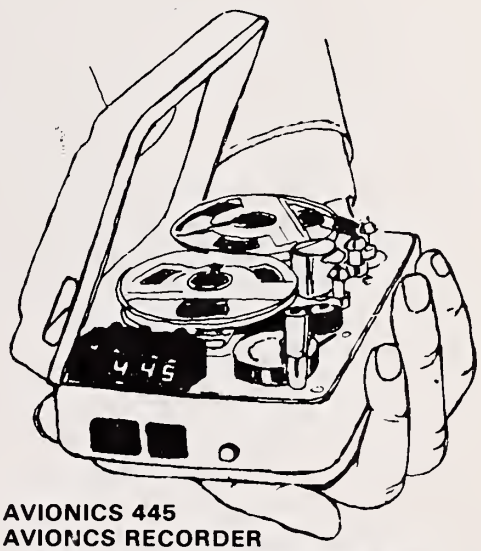
SCANNING CENTERS: Boca Raton Florida and Atlanta, Georgia

APPLICATIONS:

Diagnosis of Arrhythmia, Sick-Sinus,
Ischemia, Conduction Defects,
Pacemaker Function,
Correlate drug therapy and assay with 6 hour recording; Make 6 hour recordings part of annual health exams; record 4 to 6 patients per tape.
Holter Monitor your treadmill stress tests and record the following 23 hours.

FEATURES:

The latest state-of-the-art Recorder — FREE!
On-site training of your staff
All tape reports phoned
Mounted reports on your desk within 24 hours
No recording or scanning equipment obsolescense
Highly skilled, experienced Holter technologists scanning your tapes.



AVIONICS 445
AVIONCS RECORDER
1.6 lbs. with battery and recording tape

SEND TO: NON-INVASIVE CARDIAC SERVICES, INC.
P.O. Box 1167, 315 Golfview Drive
Boca Raton, Florida 33432

Name _____

Street _____

City/State _____ Zip _____

Phone _____

☐ Please send me more information on your scanning service.

☐ Please phone me with a description of the Free Recorder & Scanning Service.

☐ Have Holter Recorder and am interested in your scanning service.

legal page
legal page
legal page

So You Want to Counterclaim

DARYLL LOVE, *Atlanta**

YOU HAVE JUST BEEN sued by a patient alleging that you negligently caused him injury and damage. It is your opinion that the patient cannot win his suit because you have done nothing wrong and no reputable physician will say that you did.

You call your lawyer and learn that he is not interested in filing a counterclaim or counter-suit against the plaintiff-patient. However, if you insist, he will prosecute the counterclaim but only on an hourly fee basis (and not on the contingency fee basis that the plaintiff-patient probably has with his lawyer). You decide to go to your lawyer's office to find out why he is so reluctant when your cause is so just.

Your lawyer, in his best bedside manner, tells you that there are basically four legal remedies for the doctor who is wrongfully sued in Georgia. Those remedies are legal actions for: (1) malicious use of civil process or malicious prosecution; (2) malicious abuse of civil process; (3) defamation of character; and (4) a suit against the lawyer directly (and not the patient) on the grounds that filing such a groundless suit violates the ethical directives or standards of his profession.

Malicious Use of Civil Process or Malicious Prosecution

As the title implies, and no matter how innocent you may have been, unless you can demonstrate that the patient's action was filed without probable cause and prosecuted with malice, you cannot recover on your counter-suit.[1] Secondly, you have the burden of proving the patient's lack of probable cause in bringing the suit and if the circumstances were such as to create in the patient's mind the reasonable belief that you were negligent, then he has established probable cause.[2] Thirdly, you cannot recover on your counterclaim unless the patient's case is terminated in your favor; that is, the plaintiff must dismiss and not re-file his case, the jury must return a verdict in your favor, etc.[3] Finally, you must be able to prove that you sustained some special injury or special damage ". . . over and beyond damages for humiliation and ridicule, or attorney fees and other expenses of defending the litigation."[4] Lacking any one of the four elements: (a) malice, or (b) want of probable cause, or (c) a final determination of the case in your favor, or (d) special injury or special damage, you cannot recover under this legal theory.

Abuse of Process

Under this theory, it is not necessary to show that the patient's suit against you ended in your favor. However, the essential element for an action for malicious

* Prepared at the request of The Medical Association of Georgia. Mr. Love is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, C&S Bank Building, Atlanta, Ga. 30303.

abuse of civil process is ". . . an ulterior purpose and an improper act in the use of the action."[5] Finally, you must again prove special injury or special damage as well.

Defamation

The allegations contained in the complaint state that you were negligent and unqualified, that you violated acceptable medical practice standards, etc. As a matter of fact, your patient's lawsuit is a matter of public record and anybody can go down to the courthouse and read it. But you have not been libeled or defamed, because all charges, allegations, etc., contained in pleadings filed with a competent court are privileged and you cannot maintain a suit based on what is said. However false and malicious, the allegations are not libelous or defamatory unless they are wholly impertinent and immaterial.[6]

Lawyer's Malpractice or the Lawyer's Ethics

The patient has dismissed his case or the jury has returned a verdict in your favor. Rather than suing the patient, you may feel that he was a poor misguided soul and the real demon was his contingent-fee lawyer. Under Georgia law, lawyers may neither encourage the commencement nor the continuance of a lawsuit from any motive of passion or interest;[7] they are forbidden to handle a legal matter which they are not competent to handle without associating a lawyer who is competent;[8] and they are forbidden to file a lawsuit when it is obvious that the suit would serve merely to harass or maliciously injure another.[9] However, these ethical directives or standards[10] are subordinate to the first duty of a lawyer which is ". . . [N]ever to reject, for a consideration personal to themselves, the cause of the defenseless or oppressed."[11] The breach of any ethical directive or standard cannot be the basis for your civil suit against the lawyer.[12]

Conclusion

Under the present state of Georgia law any other or further remedies for the wrongfully sued physician must be created by the Georgia Legislature. In the meantime, you should be satisfied with winning the case. Isn't that what you expect?

REFERENCES

1. *Ayala v. Sherrer,* 135 Ga. App. 431, 218 S.E.2d 84 (1975).
2. *Ayala, supra,* 135 Ga. App. at 434.
3. *Greer v. State Farm,* 139 Ga. App. 74, 76, 227 S.E.2nd 881 (1976).
4. *Greer, supra,* 139 Ga. App. at 79.
5. *Myers v. Clark,* 126 Ga. App. 154, 155, 190 S.E.2d 134 (1972).
6. *Finish Allatoona's, etc. v. Burruss,* 131 Ga. App. 572, 575, 206 S.E.2d 679 (1974).
7. Ga. Code Ann. §9-601(5).
8. State Bar of Georgia, Rules and Regulations, Directory Rule DR6-101(A)(1).
9. State Bar of Georgia, Rules and Regulations, Directory Rule DR7-102(A)(1).
10. A violation of these guidelines is punishable through contempt proceedings. See *Tingle, infra.*
11. *Tingle v. Arnold, Cate & Allen,* 129 Ga. App. 134, 137, 138, 199 S.E.2d 260 (1973).
12. *Tingle, supra,* 129 Ga. App. at 138.

Capital Cadillac

SELLS AND LEASES

CADILLACS

FOR LESS THAN

ANY OTHER DEALER IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

Invest in Rare Silver

Rare medallic history of the United States. 200 large solid sterling silver medals, each with history of a different year. Over 8 years to assemble and complete.

Each medal is individually hallmarked to certify that it is solid sterling silver. Each medal of this rare First Edition Proof Set has serial number which will be registered in your name to provide excellent protection. One of only a relatively few sets minted in this brilliant Proof condition.

Special purchase price. Purchase now and receive valuable bonus collection. For information, call

261-4902

MAG SERVICES INCORPORATED

QUALITY AND INEXPENSIVE

PRINTING SERVICES FOR DOCTORS

PRESCRIPTION BLANKS

Standard Size 4¼ x 5½ in Pads of 100

500	1000	2000	4000
5.75	7.95	14.65	26.55

BUSINESS CARDS OR APPOINTMENT CARDS

	1000	2000	4000
White Stock One Side	6.95	12.65	22.95
For Color Stock, Add	1.00	2.00	4.00
For Two Sides	11.85	20.95	39.95

LETTERHEADS

20 LB. WHITE BOND				
SIZE	500	1000	2000	4000
7¼ x 10½ 8½ x 11	11.16	15.70	24.98	42.72
20 LB. RAG CONTENT (25%)				
7¼ x 10½ 8½ x 11	13.90	21.16	35.91	64.75

ENVELOPES

TO MATCH LETTERHEADS

24 LB. WHITE WOVE				
SIZE	500	1000	2000	4000
6¾	12.88	15.96	25.51	47.90
Monarch	13.70	17.59	28.76	54.40
#10	13.77	17.74	29.06	55.00
20 LB. RAG CONTENT				
Monarch	20.23	30.63	54.86	106.60
#10	20.86	33.97	57.43	111.75

WINDOW ENVELOPES

24 LB.

SIZE	500	1000	2000	4000
6¾	13.83	17.84	29.26	55.40
#10	14.85	19.89	33.36	63.60

Composition and type set charges are in addition to quoted prices.

UNIFORM INSURANCE CLAIM FORMS (Approved by AMA)

$18.50/1000 -- Single Copies -- Pads of 100

SEND ORDERS TO:

MAG SERVICES, INC.

(a service company of the Medical Association of Georgia)

968 PEACHTREE ST., N.E.
ATLANTA, GA. 30309
(404) 873-4136

the association
the association
the association

NEW MEMBERS

Angel, Jose F., Ga. Medical Society—Act—Anes
36 Medical Arts Center, Savannah 31405

DuBose, David M., MAA—Act—I
Suite A-12, 6500 Vernon Woods Dr., NE, Atlanta 30328

Dunfee, James A., Cobb—Act—I
Suite 210, 2550 Windy Hill Rd., Marietta 30067

Fitzgerald, Sharon, MAA—Act
3191 Washington Rd., NE, Atlanta 30344

Howard, Albert R., Ga. Medical Society—Act—Anes
36 Medical Arts Center, Savannah 31405

Hubrich, Leon R., CWL—Act
700 Oglethorpe Ave., Athens 30601

Huddleston, Howard L., Ga. Medical Society—Act—Anes
36 Medical Arts Center, Savannah 31405

Lalani, Hamid I., Telfair—Act—FP
Doctors Building, McRae 31055

Lowe, Thomas H., Bibb—Act—I
618 Orange St., Macon 31201

Manoharan, Edakandyil, Habersham—Act—ObG
Box 667, Demorest 30535

Marino, Brenda L., Ga. Medical Society—Act—I
Box 6688, Station C, Savannah 31405

Noland, Arthur E., Camden-Charlton—AF
808 Anne St., St. Mary's 31520

Parks, James F., Hall—Act—I
419 Bradford St., Gainesville 30501

Pesnell, Larkus H., CWL—Act—Path
St. Mary's Hospital, Athens 30601

Petkovich, Mila, Ga. Medical Society—Act—Path
2108 Bay St., Savannah 31402

Ruckett, Alan N., MAA—Act—ObG
Suite 404, 340 Boulevard, NE, Atlanta 30312

Ryan, Mary H., Carroll-Douglas-Haralson—A
Route 10, Box 131, Carrollton 30110

Shuman, Rick S., Elbert—Act—FP
33 Chestnut St., Elberton 30635

Weksler, Luiz, Bibb—Act—Anes
777 Hemlock St., Macon 31201

Willson, Leroy Montgomery Jr., Bibb—Act—I
Medical Center of Central Georgia, Macon 31201

Woods, James D., Dougherty—Act—ObG
420 4th Ave., Albany 31701

Yeckley, James A., Ga. Medical Society—Act—D
835 E. 65th St., Savannah 31405

SOCIETIES

The **Bibb County** Medical Society has endorsed the building of a doctor's office building next to the Medical Center. The proposed $4.3-million Pine Street building will be built by the Macon-Bibb County Hospital Authority.

The Auxiliary to the **Cobb County** Medical Society recently presented $250 to the Cobb County Unit of the Georgia Heart Association. The Unit's CPR Committee had been instructing auxiliary members in basic CPR. Several members of the auxiliary have been certified as cardiopulmonary resuscitation instructors.

New officers for the **DeKalb County** Medical Society are: Stanley P. Aldridge, M.D., President; Charles McDowell, M.D., Vice President, and Ernest Fokes, M.D., Secretary-Treasurer.

Doctor's Day was March 30, prompting numerous activities across the state, all sponsored by auxiliaries to county medical societies.

The **Carroll-Douglas-Haralson** Medical Society Auxiliary featured a collection of old medical equipment and supplies in a showcase at the Neva Lomason Library. Another showcase there had samples of modern plastic and disposable medical supplies. Materials for the showcases were collected by Mrs. D. S. Reese, wife of the late Dr. Reese and first president of the CDH Auxiliary, along with the current president Mrs. Ed Grant.

A dinner-dance was held at Aunt Fanny's Cabin in honor of **Cobb County** doctors. Other activities included an annual Memorial Service at Kennestone Hospital, honoring deceased physicians of the county.

A barbeque and square dance were part of the celebration for the **Crawford W. Long** Medical Society. Its Auxiliary also sponsored the placing of a display board in Athens General Hospital on which are the names of 13 retired physicians who practiced and/or lived in Athens.

The **Floyd-Polk-Chattooga** Auxiliary honored Rome-area physicians who have contributed their services in the community for 40 years or longer. **Laurens County** joined with Laurens Memorial Hospital to honor its doctors with a breakfast. The auxiliary also sponsored a dinner at the Dublin Club and an exhibit at the County Library.

The **Medical Association of Atlanta's** Auxiliary had a number of activities in honor of the day, in addition to presenting red carnations to the doctors of Fulton Coun-

ty. A band composed of physicians entertained at a Garden Center dinner sponsored by the Auxiliary to the **Richmond County** Medical Society.

Each member of the Auxiliary to the **Tift County** Medical Society donated a pint of blood in a blood drive connected with Doctor's Day activities. The group also held a banquet at the Springhill Country Club and sponsored a display at the library.

Walker-Dade-Catoosa physicians were honored by their Auxiliary at Hutcheson Memorial Tri-County Hospital. Auxiliary members of the **Whitfield-Murray** County Medical Society served as hosts at the Hamilton Memorial Hospital, providing early morning refreshments for the physicians.

PERSONALS

First District

E. R. Hensley, M.D., of Waynesboro has been named a diplomate of the American Board of Family Practice (ABFP).

John Mooney, M.D., was the featured speaker at the March meeting of Lodge 469 of the Free and Accepted Masons in Statesboro. Dr. Mooney is full-time director of Willingway Hospital.

Second District

The ABFP has named Moultrie physician, **Lanny R. Copeland, M.D.,** a diplomate.

Third District

The Stewart-Webster Hospital, Richland, has named **William McCall Calhoun, M.D.,** of Buena Vista, Chief of Staff. **Larry E. Brightwell, M.D.,** of Richland was elected secretary-treasurer.

C. Denton Johnson, M.D., and **Robert Nelson Murdock, M.D.,** of Columbus, and Jerry Stephens Chase, M.D., of Phenix City, Alabama, have been named diplomates of the ABFP.

Fourth District

F. James Funk Jr., M.D., Associate in Orthopedic Surgery at Emory University School of Medicine and team physician for the Atlanta Falcons, was scheduled to speak at the 21st Annual Postgraduate Course on Fractures and Other Trauma, May 11-14 in Chicago. The course is sponsored by the Chicago Committee on Trauma of the American College of Surgeons.

Alfred M. Holloway Jr., M.D., of Thomaston, and **Ferrol A. Sams, Jr., M.D.,** of Fayetteville, have been named diplomates of the ABFP.

Chamblee physician **Wytch Stubbs, M.D.,** has received the 1976 Julius A. McCurdy Citizenship Award. The award, established in 1974, honors the outstanding accomplishments of members of the medical profession in activities outside their regular practice. Recipients are selected by the DeKalb County Medical Society.

Dr. Stubbs has been the volunteer medical director of the Scottdale Medical Clinic since 1973 and has recruited some 20 physicians to assist in the clinic's work of providing medical care to needy Scottdale residents. He is also involved in teaching freshman medical students at Emory University and is team physician for the Druid Hills High School.

Fifth District

Atlanta pediatrician **Stephen King, M.D.,** spoke at a meeting of Cesarean Concern, Inc., on March 16. His topic was maternal-infant bonding and Cesarean-born infants.

Sixth District

William A. Dodd, M.D., recently addressed the members of the governing council of the American Health Care Association at its meeting held in Washington, D.C. Dr. Dodd, president of the Georgia Association of Nursing Home Medical Directors, spoke to the national group about the history, purposes and functions of the Georgia Association.

The Heard County Board of Health honored **George B. Fisher, M.D.,** with an award for 25 years of dedicated service to the people of that county and surrounding areas. During those 25 years, Dr. Fisher was Chief of the Medical Staff of the Heard County Memorial Hospital and served as County Physician for 20 years.

Seventh District

Morgan Charles Adair, M.D., of Rome, and **Ralph Rudicil Greene, M.D.,** of Ringgold have been named diplomates of the ABFP.

The Dalton-Whitfield Chapter of the American Association of Retired Persons featured **Royal Farrow, M.D.,** as speaker at its March meeting. The Dalton physician spoke on various respiratory diseases which affect many middle-age and older persons.

Scott MacLeod, M.D., a cardiologist on the Harbin Clinic Staff in Rome, was recently elected to fellowship in the American College of Cardiology.

Kennesaw physician **Stephen C. May, Jr., M.D.,** was recently sworn in as a member of the Joint Advisory Board of Family Practice, a six-member board created by last year's legislature. In his role as board member, Dr. May said he will continue to wage a campaign for more family physicians throughout the state.

Joel D. Todino, M.D., chief of medicine at Redmond Park Hospital in Rome, has been named volunteer chairman of the Georgia Heart Association's District 1. In this capacity, he will be responsible for enlistment, orientation and training of heart volunteer leaders in the nine counties in the district. A clinical instructor in medicine at Emory University School of Medicine, Dr. Todino is also serving as a volunteer chairman of the Floyd County Heart Unit.

Eighth District

Fred E. Gilliard, M.D., of Douglas, has been named a diplomate of the ABFP.

Ninth District

Ninth District recipients of the status of diplomate of the ABFP are: **William Robert Dunn, M.D.,** of Cumming; **Guerrant Heath Perrow, M.D.,** of Jasper.

Tenth District

Asa Daniel Duggan, M.D., of Washington, and **Rick Steven Shuman, M.D.,** of Elberton, have been named diplomates of the ABFP.

SHERWOOD'S
PROFESSIONAL PRACTICE SALES

A unique business brokerage service specializing in the confidential presentation of professional practices for sale.

Sherwood's Commercial Brokers

North Center, Suite 201
4319 Covington Highway
Decatur, Georgia 30035
404/288-1330

MEDICAL CAREERS

M.D.s
Hospital Administrators
Nursing Home Administrators
Comptrollers
Department Heads
Office Managers
Medical Social Workers
L.P.N.s
Master Social Workers
A.S.C.P.
Directors of Nursing
Physicians' Associates
R.R.A.
X-Ray Technicians
Medical Assistants
Medical Secretaries
A.R.T.
Medical Sales

ALL MEDICAL & PARAMEDICAL

O'KEEFE
PERSONNEL SERVICES

3384 Peachtree Road, N.E.
(404) 266-1153

Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.

Armour Pharmaceutical Company
Greyhound Tower
111 West Clarendon Avenue
Phoenix, Arizona 85077

☐ Send latest information on Paget's Disease of Bone.
☐ Have your representative call on me.

Dr. _____

Address _____

City _____ State _____ Zip _____

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

Eager and Simpson

Since 1919

- ☐ Hospital Fittings of Orthopedic Supports
- ☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

WHAT ARE YOUR OBSERVATIONS

on pre-hospital care and emergency room care? What have you observed about Emergency Medical Technicians? Do you have ideas for how emergency services can be approved?
The EMS Newsletter would like to publish your 250-500-word articles on this subject. Submit any contributions you may have to:
EMS Newsletter Editor
Emergency Health Section
618 Ponce de Leon Ave.
Atlanta, Ga. 30308 Or Call (404) 894-5170

A unique hospital specializing in treatment of...

ALCOHOLISM
DRUG ADDICTION

In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director



Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

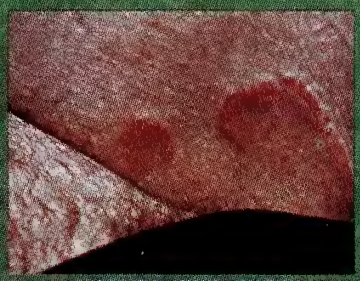
When Griseofulvin is indicated...



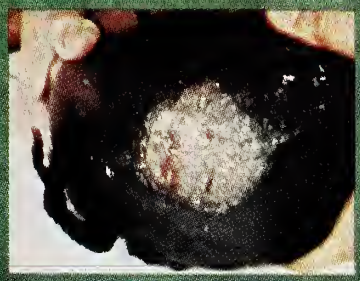
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



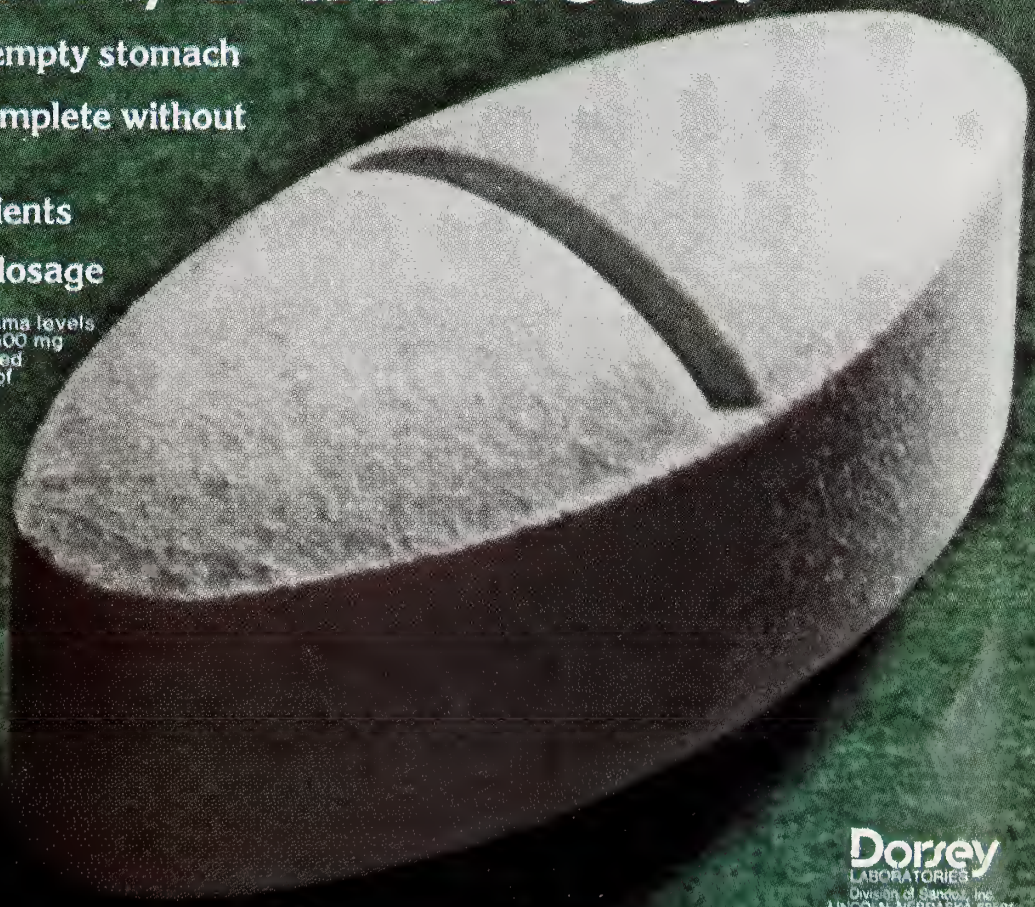
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

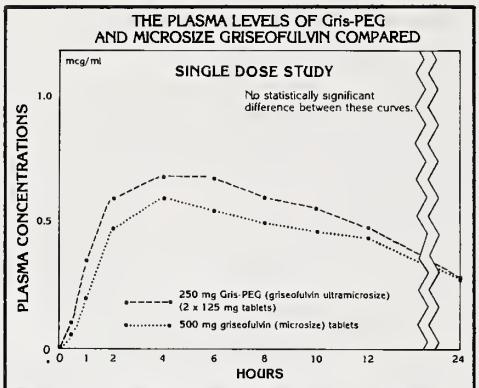
†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



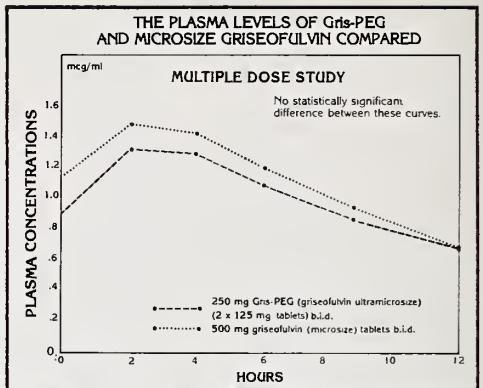
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION
Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION
Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS
Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS
This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS
Prophylectic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungel Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorlgenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboretory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usege in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS
Patients on prolonged therapy with any potent medicatlon should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

AOVERSE REACTIONS
When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticeria, end rarely, angioneurotic edema, and may necessitate withdrewal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therepy. Other side effects reported occasionally are orel thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

OOSAGE AND ADMINISTRATION
Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivelent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungel infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided deily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (epproximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinicel experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED
Gris-PEG (griseofulvin ultremicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in thet eech teblet contains 125 mg of ultremicrosize griseofulvin biologically equivelent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG ere biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 end 500 scored, film-coated teblets.

Dorsey LABORATORIES
Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

The Month in Washington

This regular monthly summary of Washington news is prepared by the Washington Office of the American Medical Association.

In the name of the "sunshine law," the government released the names of physicians, groups and laboratories that did more than $100,000 in Medicare business last year. It marked the first breach in the Medicare program's long-standing policy against disclosing such information.

The over-$100,000 category included 409 physicians, 1,752 medical groups and 58 laboratories. This compared to 2,533 physicians, dentists, and pharmacies listed in the latest Medicaid report of more than $100,000 intake last November.

The American Medical Association branded the releasing of the names as "only serving to badger a large segment of the profession and to establish guilt by innuendo." AMA Executive Vice President James Sammons, M.D., said "there is a basic dishonesty in the broadcast release of the names of individuals receiving Medicare payments." Dr. Sammons added that if "HEW thinks any physician on this list is guilty of fraud, HEW should say so. We will assist in any case where there is good reason to suspect wrong doing."

Dr. Sammons said the physicians are identified by HEW as individual recipients of Medicare funds, whereas the payments are often for services provided by many others as well. Many of the physicians listed are hospital-based radiologists, pathologists, anesthesiologists, he said. "We would also point out that these services are paid for at a rate set by Medicare and based on prevailing charges two years out of date."

Predictably, press reaction was uneven. Some press took the trouble to check before using the story. Most press did not. All too typical were headlines like this one, from the *Fort Lauderdale Sun-Sentinal:*

"HEW RELEASES NAMES OF DOCTORS ON MEDICARE GRAVY TRAIN."

Few stories bothered to explain that the figures cited are gross, not net; or that HEW's dollar totals included not only payments to the physician but payments made directly to the beneficiary where the beneficiary is responsible for paying the physician's bill.

Having gone through a similar experience in November of 1976, when the Social and Rehabilitation Service made public a list of physicians, dentists, pharmacies and laboratories that had received $100,000 or more from Medicaid in 1975, the AMA immediately began checking for accuracy as many as possible of the names and amounts listed as paid to solo practitioners.

By the *Month in Washington* press time, some 166 physicians listed in solo practice were contacted in 30 states and the District of Columbia. Of this group:

* 82 were incorrectly listed as solo practitioners;
* 5 had incorrect amounts attributed paid to them;
* 22 reported both the solo designation and the amount were incorrect.

Some 65.7 percent of the information released on the 409 physicians listed as solo practitioners was therefore incorrect.

Complaints from individual physicians victimized by these inaccuracies poured in to the press. A roundup by the *Associated Press* pointed out some of the injustices done by the HEW release in which two out of three solo practitioners were inaccurately listed.

The *Washington Star* took editorial note of HEW's inaccuracies under the heading: "A SLOPPY PIECE OF WORK."

The physicians contacted by the AMA and state medical societies reported harassment by angry patients, crank telephone calls, children taunted at school as the children of a crook, anonymous threats, attacks by colleagues, and continuing embarrassment within their communities.

A number of Congressmen have inserted remarks into the *Congressional Record* with respect to HEW's disgraceful performance.

HEW Secretary Joseph A. Califano has privately admitted dismay and has publicly stated that a corrected list will be forthcoming shortly.

Fraud vs. Abuse

The AMA has told the government that fraud and abuse are different problems deserving different treatment.

In a letter to HEW Secretary Califano, the AMA said:

"Frankly, we find it difficult to equate 'abuse' of Medicare and Medicaid programs with some legally definable criminal action. Indeed, it is unfortunate that 'fraud and abuse' have been linked so often in public discussion and departmental releases that the clearly criminal aspects of 'fraud' have migrated to 'abuse' as well."

AMA Executive Vice President James Sammons, M.D., said "fraud" is a reasonably well-defined legal concept—misrepresentation with the intent to obtain money or other goods to which one is not entitled—and has always been clearly subject to legal penalties. Dr. Sammons said examples include billing for services not rendered, etc. "The medical profession has always opposed such practices by its members and urges prosecution of those charged with fraud.

"However," he wrote, "abuse is a much more ambiguous term." A "fact sheet" on Medicaid fraud and abuse issued by the Social and Rehabilitation Service states that a provider is "abusing" the program if he files claims and receives payment for services "that are not allowed by federal or state Medicaid laws or regulations." If "abuse" of a program by a provider implies some guilt on his part, this definition is clearly inadequate, since it leaves out any reference to the provider's knowledge of the exclusion, noted Dr. Sammons.

The AMA said the decision as to appropriateness of care "is a professional decision, not a legal one, and we would strongly urge that no attempt be made to bring it within the courtroom, along with prosecution of fraud." Legitimacy and appropriateness of treatment

should first be explored by the review committees already established for this purpose at the community level, said Dr. Sammons. "When they agree that the treatment is, indeed, inappropriate and excessive, efforts should be made by his peers to persuade the erring physician to follow a more appropriate course of treatment, but the punitive action should be limited to those already authorized by law—non-reimbursement of excess care and, where the pattern of over-use or over-treatment continues, exclusion of the individual from the program."

He concluded, "We believe that this is both appropriate and sufficient in the way of penalty for actions which the physician himself may consider honest and non-culpable, and we would therefore urge that, while fraud should indeed be prosecuted to the extent of the law, 'abuse,' in this sense, should be handled within the framework of Peer Review and program administration controls."

Bill Much Too Broad

A bill aimed at rooting out fraud and abuse in federal health programs has started down the legislative path in Congress. The AMA applauded the objective, but said the bill is so broadly drawn that it allows investigation of "the actions of almost every practicing physician in the United States."

The minority of physicians who abuse Medicare and Medicaid should be brought to justice, the AMA said, but "justice is not served if all practitioners are subjected to harassment and restraint so that a few malefactors may be apprehended."

Edgar T. Beddingfield, M.D., Chairman of the AMA's Council on Legislation, testified before an unusual joint hearing by the health subcommittees of the House Ways and Means and House Commerce Committees. (Ways and Means is responsible for Medicare; Commerce, for Medicaid.)

To the extent that the legislation was aimed at the "Medicaid mill" it has "far exceeded the mark," said Dr. Beddingfield. "Since this bill has been characterized as the 'Medicaid mill' Fraud and Abuse Bill, practically all group practices could be stigmatized because of the broad application of its provisions."

The broad approach of the bill is "aimed at a large proportion of all practicing physicians, casting its stigma of impropriety upon the tens of thousands of physicians who fall within its purview," the AMA witness said. "Virtually all group practices in the United States would be subjected to the same requirements as the so-called 'Medicaid mill.' "

All groups of two or more practitioners would be subject to the extensive disclosure of records provisions, Dr. Beddingfield noted, adding that all practicing physicians who render Medicare and Medicaid services would be subject to review by Professional Standards Review Organizations (PSRO).

Continuing his criticism of the legislation, Dr. Beddingfield said it "endangers the confidentiality of patient records, and certain provisions cannot be justified as needed or even as a wise tool to combat fraud."

FBI Investigates

To counter charges that his Department has been lax in cracking down on fraud and abuse in health programs, HEW Secretary Califano has called in the FBI.

He said FBI agents will work "full blast" on Medicare and Medicaid misdoings until HEW's own office of investigations is "up to full speed."

Califano made the statements following a report by the Senate Special Committee on Aging contending that illegal kickbacks are "rampant" in the Medicaid program. Summarizing testimony given the Committee last year, the report said nursing homes are the chief offenders, but "increasing evidence points to hospitals, medical practitioners, clinical laboratories and other suppliers."

Not making Califano's life any easier was an allegation by John Walsh, former director of HEW's Office of Investigations, that the new HEW Secretary and his Under-Secretary Designate, Hale Champion, tried to impede an investigation of fraud in a San Jose, California, Medicaid project. Walsh, who resigned his post, said he was told he had to clear the investigation with his superiors. Califano and Champion angrily denied they were in any way attempting to influence the course of the probe.

"I did not in any way hinder or impede our fraud investigation—nor did Mr. Champion—in California or elsewhere," Califano said on NBC's Meet the Press program. "Everything that I've done in this area has been designed to make those investigations go faster and better."

TV Violence and the Real Thing

The weight of scientific evidence points to a relationship between television violence and increased aggressive behavior in some youthful viewers, the AMA has told Congress.

The AMA called on the TV industry to recognize its social responsibilities, to reduce the amount of violence and to respond with greater sensitivity and diversity in its programming policies. "That television violence represents a serious issue in the mind of the public is a consideration the broadcasting industry can no longer ignore," declared Robert Stubblefield, M.D., consultant on mental health matters to the AMA.

Testifying before the House Commerce Subcommittee on Communications, Dr. Stubblefield said "television could teach many positive lessons and behavior that would provide alternatives to the violent and antisocial problem-solving so often conveyed in today's programming."

Violence now is a prevalent theme on TV, said the AMA spokesman. He noted earlier testimony of George Gerbmer, PhD, that there was more violence during the fall season programming than at any other time in the past decade.

Said Dr. Stubblefield: "These results are especially alarming since just three years ago network executives assured another Congressional subcommittee that efforts were well under way to reduce the amount of gratuitous violence."

The AMA believes that the television medium "has not even begun to realize its potential" in "prosocial programming," he said.

"In my opinion," Stubblefield added, "the television industry cannot have it both ways—claiming that they merely entertain, facilitate abreaction and ventilation of pent-up emotions, yet denying that they shape and influence behavior. Bluntly stated, shaping and influ-

encing behavior that is stimulating the sale of products is precisely one of the major uses of television."

New FDA Head

The new Commissioner of the Food and Drug Administration is Donald Kennedy, PhD, a neurophysiologist from Stanford University. Dr. Kennedy is the first non-physician to head the agency in 11 years but he doesn't place much significance in that fact.

"I've been active in the community of neurophysiologists for some time. About half my colleagues who are good scientists have M.D.s, the other half have PhDs. If I didn't know something about their personal histories I wouldn't know, from their ability to do what they do, which was which. In other words, you can be a good scientist with either degree. Furthermore, I don't think an M.D. confers you with an automatic set of prejudices about regulation either."

HEW Secretary Califano praised Dr. Kennedy in announcing the appointment and said "it is imperative that the FDA act only in the public interest and with must greater dispatch than it has in the recent past."

Responding to a query on FDA's legendary speed Dr. Kennedy said, "I think anyone would like to see a larger amount of dispatch per unit of protection. Obviously, the first thing one wants to look at in any agency is how it is going to pursue its fixed responsibilities with great alacrity. The classical regulatory dilemma is that on the one hand there is the wish to minimize the public cost of too speedy introduction. On the other hand you'd like to be able to figure the opportunity-cost that you're paying in delayed innovation. It's no trick to describe the problem. The trick is to measure it for any given case.

New Top Health Official

Christopher C. Fordham, M.D., Dean of the University of North Carolina Medical School, is the choice of the Carter Administration as Assistant Secretary for Health at HEW.

The naming of the federal government's top health official had been the subject of much speculation and interest over the past weeks. The selection of the Assistant Secretary for Health (ASH) in a new Administration is considered an important guide to the type of health policies HEW will pursue.

Dr. Fordham, 49, is a board certified internist and a member of the AMA. He received his medical degree from Harvard University Medical School. He is well-known in North Carolina and is regarded generally as a moderate on socio-economic medical issues.

HEW Inspector General

Thomas D. Morris, a member of the senior staff of the Brookings Institution was named to the newly created post of Inspector General of HEW.

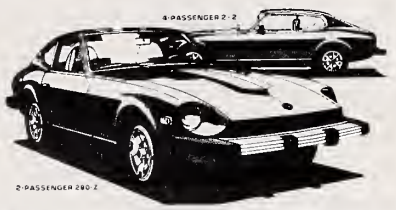
The job was established by Congress last year to oversee a $25 million program, to find fraud and abuse in various HEW programs, especially Medicaid. Morris will have a staff of 1,000 auditors and 100 investigators.

Morris, 63, was Assistant Secretary of Defense in charge of the cost reduction program and procurement operations from 1961 to 1968 and was Assistant Comptroller General from 1970 to 1975. For the past year, he has been a senior staff member of the Brookings Institution in Washington.

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455-1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND ...
We have the South's best service for the whole Datsun Line!

BE THE DOCTOR YOU WANT TO BE.

Today, Navy Medicine gives you the opportunity to be the doctor you want to be. We offer a challenging practice with a minimum of administrative overhead. Plus excellent facilities and support personnel.

In addition, a Navy practice gives you time to spend with your family. Associate with other highly motivated physicians. Further your schooling. Even enjoy 30 days' paid vacation every year.

All this, plus a starting salary of $30,000 or more a year, depending on your experience.

For more information, contact:

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Menieres Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

Medical Meeting Calendar

JUNE

1-3—*Lexington, KY;* **INTERNATIONAL CONFERENCE ON THE CLINICAL USES OF CARCINOEMBRYONIC ANTIGEN (CEA);** Category 1 Credit; Contact: Frank R. Lemon, MD, Continuing Education, College of Medicine, University of Kentucky, Lexington 40506.

4—*Atlanta;* **INTERNAL MEDICINE: A SUBSPECIALTY REVIEW ON INFECTIOUS DISEASES (VIRAL INFECTIONS AND VACCINES);** Category 1 Credit; Contact: H. Kenneth Walker, MD, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1608.

4—*Pensacola Beach, FL;* **ANESTHESIA SEMINAR;** Category 1 Credit; Contact: Florida Academy of Family Physicians, Suite 109, 4057 Carmichael Ave., Jacksonville, FL 32207.

8-10—*Lake Lanier;* **ANNUAL MEETING & SCIENTIFIC ASSEMBLY OF REGION III, NATIONAL MEDICAL ASSOCIATION;** Category 1 Credit; Contact: National Medical Association, 2109 East St., NW, Washington, DC 20037.

9-10—*Atlanta;* **FIRST ANNUAL CONFERENCE ON PAIN: "HOW TO MEASURE PAIN";** Category 1 Credit; Contact: Steven F. Brena, MD, Anesthesiology and Rehabilitation Medicine, Emory Univ. School of Medicine, Pain Control Center, Emory University Clinic, Atlanta 30322.

9-11—*Lexington, KY;* **WANGENSTEEN SYMPOSIUM ON SURGICAL DISEASES OF THE INTESTINE;** Category 1 Credit; Contact: Univ. of Kentucky College of Medicine, Continuing Education, 800 Rose St., Lexington 40506.

9-11—*Jekyll Island;* **SELECTED TOPICS IN INTERNAL MEDICINE;** Category 1 Credit; Contact: Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

10-11—*Atlanta;* **AMERICAN MEDICAL ASSOCIATION'S HOSPITAL MEDICAL LEADERSHIP WORKSHOP;** Category 1 Credit; Contact: American Medical Association, Dept. of Hospitals and Health Facilities, 535 North Dearborn St., Chicago, IL 60610, PH: 312/751-6657.

11—*Atlanta;* **INTERNAL MEDICINE: A SUBSPECIALTY REVIEW ON INFECTIOUS DISEASES (HEPATITIS);** Category 1 Credit; Contact: H. Kenneth Walker, MD, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1608.

12-15—*Clearwater Beach, FL;* **FLORIDA SUNCOAST PEDIATRIC CONFERENCE SECOND ANNUAL MEETING;** Category 1 Credit; Contact: Theron A. Ebel, MD, Continuing Medical Education, Univ. of South Florida, Tampa 33620.

13-15—*Lake Lanier Islands;* **FERTILITY CONTROL: WHERE ARE WE NOW? WHERE ARE WE GOING?** Category 1 Credit; Contact: Assoc. Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1676.

13-24—*Atlanta;* **LAB METHODS IN ANAEROBIC BACTERIOLOGY;** Category 1 Credit; Contact: Center for Disease Control, Bureau of Labs, U. S. Public Health Service, Clifton Rd., Atlanta 30333.

15-17—*Hilton Head, SC;* **GEORGIA STATE MEDICAL ASSOCIATION CONVENTION;** Contact: James F. Densler, MD, 319 West Lake Ave., NW, Atlanta 30318.

18—*Atlanta;* **INTERNAL MEDICINE: A SUBSPECIALTY REVIEW ON INFECTIOUS DISEASES (FEVER & DIAGNOSIS);** Category 1 Credit; Contact: H. Kenneth Walker, MD, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1608.

18-22—*San Francisco;* **126th ANNUAL CONVENTION OF THE AMERICAN MEDICAL ASSOCIATION;** Category 1 Credit; Contact: AMA, 535 N. Dearborn St., Chicago, IL 60610.

20-July 3—*Switzerland, Italy & France;* **ALPS-RIVIERA MEDICAL SEMINAR,** Category 2 Credit; Contact: Medical Assoc. of Atlanta, 875 W. Peachtree St., NE, Atlanta 30309.

20-24—*Miami;* **MEETING OF AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY;** Category 1 Credit; Contact: Ms. M. H. Henry, 4137 Erie St., Willioughby, OH 44094.

23-25—*Hilton Head, SC;* **CURRENT STATUS AND CONTROVERSIES IN PACEMAKERS;** Category 1 Credit; Contact: Dale E. Braddy, Director of Continuing Education, Amer. College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.

23-26—*Bal Harbour, FL;* **POSTGRADUATE SEMINAR IN RESPIRATION AND RESPIRATORY CARE AND SEMINAR FOR INTENSIVE CARE AND CRITICAL CARE PERSONNEL;** Category 1 Credit; Contact: Mount Sinai Medical Center of Greater Miami, 4300 Alton Rd., Miami Beach 33140.

25—*Atlanta;* **INTERNAL MEDICINE: A SUBSPECIALTY REVIEW ON INFECTIOUS DISEASES (SELF-ASSESSMENT QUIZ);** Category 1 Credit; Contact: H. Kenneth Walker, MD, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1608.

JULY

12-15—*Atlanta;* **MEDICAL OFFICE MANAGEMENT INSTITUTE (FOR MEDICAL OFFICE MANAGERS);** Contact: Conomikes Assoc., Inc., 4270 Promenade Way, Marina del Rey, CA 90291, PH: 213/823-4661.

18-22—*Jekyll Island;* **TAX, RETIREMENT, AND ESTATE PLANNING AND FINANCIAL INVESTMENTS;** Category 2 Credit; Contact: Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

30—*Macon;* **EMERGENCIES IN FAMILY PRACTICE** (Sponsored by Family Practice Residency Program) Category 1 Credit; Contact: Don Purdy, MD, 784 Spring St., Macon 31201.

AUGUST

1-5—*Myrtle Beach, SC;* **5TH ANNUAL BEACH SYMPOSIUM;** Category 1 Credit; contact: Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, NC 27103.

15-19—*Atlanta;* **ACP-MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM IV;** Category 1 Credit; Contact: American College of Physicians, 4200 Pine St., Philadelphia 19104.

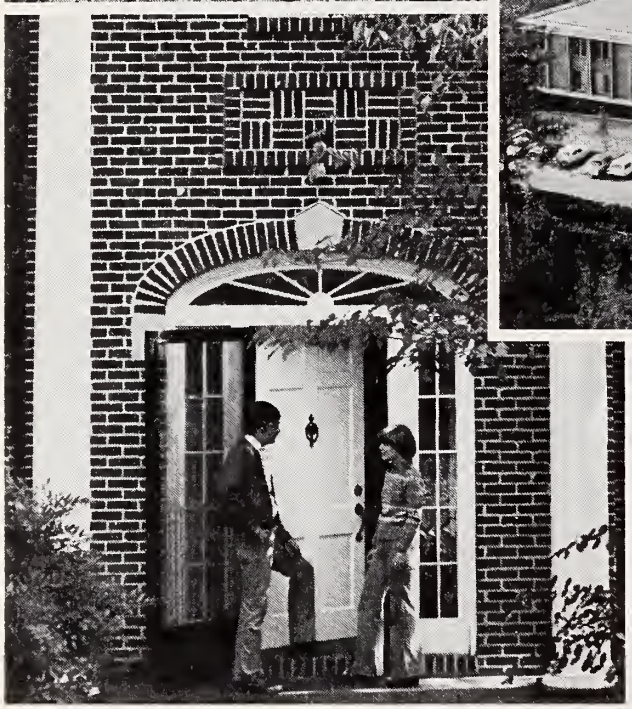
15-20—*Cashiers, NC;* **SMOKY MOUNTAIN SUMMER SEMINAR;** Category 1 Credit; Contact: Assoc. Dean for CME, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1676.

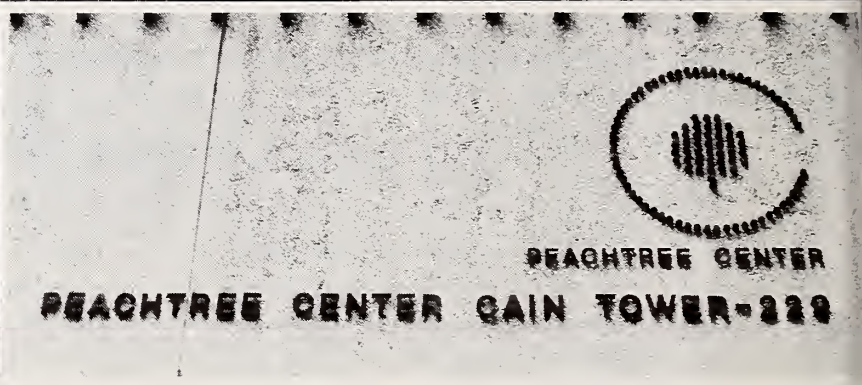
For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.











PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Classified Advertising

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialities included. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

FAMILY PHYSICIAN OR GENERAL INTERNIST wanted to join two-man well-established family practice group. Primarily adult practice, no O.B. Pleasant community of 50,000, modern 225 bed hospital, excellent benefits. May inquire through William L. McDaniel, Jr., M.D. or Robert W. Simmons, M.D., 1203 Memorial Drive, Dalton, Georgia 30720, Telephone: 404-278-0138.

ALABAMA: Emergency Physician: Full time, $60,-000+ per year, fee for service, group health insurance, malpractice paid, funded continuing education, 305 bed regional medical center plus 350 bed community hospital and 100 bed community hospital with inhouse and outpatient responsibility. New ED facilities within 18 months with interns and resident teaching. Contact: Medical Director, P. O. Box 9639, Marina del Rey, CA 90291, Phone (213) 822-1312.

VACATION HOME on Chattahoochee River in the Mountains. I have a 3-br., 2-bath chalet with spectacular view of the River. Two hours from Atlanta. Perfect place to "get away from it all." 4 acres. Excellent fishing, hunting, canoeing. Contact Forte C. Rabb, M.D., Gainesville, 404/536-9620.

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital. 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Call 262-3580.

BOARD-CERTIFIED INTERNIST—VA Center, Dublin, Georgia. This is a full-time position which requires an internist with broad experience in the field of internal medicine preferably with emphasis in cardio-pulmonary diseases. Benefits—Life Insurance; Group Health; 30 annual and 15 days sick leave yearly; Educational Details and excellent retirement. No Malpractice Insurance necessary under Tort Claim Act when physician is serving in his or her capacity as VA employee. Dublin is a pleasant, tree-lined, smogless community within three-hour drive of uncrowded mountains and coastal areas. It is within two to three-hour drive of medical ceners of Atlanta and Augusta. Ideal opportunity for both maintaining adequate income and preparation for Boards. Contact John B. Morton, M.D., Acting Chief of Staff, VA Center, Dublin, GA 31021, Telephone 912-272-1210, Ext. 202. Non-discrimination in employment.

FAMILY PRACTICE well established (40 years). Well equipped office for rent or purchase. Large Nursing Home and large area to care for. Hospital staff privileges available. This area is badly in need of doctors and after 40 years I am ready to retire. Contact: C. Roy Williams, M.D., Wadley, Georgia 30477. Telephone: (912) 252-5915, (912) 252-5456, (404) 541-0341.

GP—WANT MORE Free time? Approaching retirement? I've got an idea! Share practice in perfect location with new, fully-equipped office, including lab and X ray. No in-patient care. Work Thursday, Friday, Saturday, Monday, Tuesday and Wednesday; then be off one week. Nothing to buy. North metro Atlanta location. Please send resume to Box 5-1, c/o the *Journal*.

ESTATE SALE—Recently deceased physician. OBG and general practice. Fully equipped office suite in suburban clinic in Atlanta area with attractive lease assumable. Contact C&S National Bank Trust Dept., P.O. Box 11930, Atlanta, Ga. 30355, or call Richard Rice, 231-0622 or Don Bieger, 262-7196.

OFFICE TO SUBLET. Leaving practice. Will share office from July 1, 1977 to October 1, 1977, or sublet from October 1, 1977 to October 13, 1978. Office equipment also for sale. Decatur North Professional Building, downtown Decatur, Georgia. Call (404) 377-6459, 9-5, Monday through Friday.

Got a knack for public speaking?
Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at **(404) 876-7535; INWATS (800) 282-0224.**

Index to Advertising

Vol. 66 May 1977 No. 5

Armour Pharmaceutical Company 333
Walter Ballard Optical Company 268
Beltone Electronics Corporation 293
Blue Cross and Blue Shield of Georgia/Atlanta/ Columbus 287
Brawner Hospital, Inc. 266
Burroughs Wellcome Co. 296
Capital Automobile Company 330
Classified Advertising 343
Coca-Cola Company 269
Colonial Leasing 317
Dickey-Mangham Company 334
Dorsey Laboratories 335, 336
Eager and Simpson 334
Georgia Cancer Line 318
Georgia Society of CPAs 321
Hickman Datsun 339
Hill Crest Hospital 268
I Med, Inc. 272
Eli Lilly and Company 276
MAG Services, Inc. 330
Metropolitan Psychiatric Center 310, 311
Non-Invasive Cardiac Services, Inc. 327
O'Keefe Personnel Services 333
Ortega Pharmaceutical Company, Inc. 340
Peachford Hospital, Inc. 270, 271
Peachtree and Parkwood Hospitals 342
Pharmaceutical Manufacturers Association 274, 275
Potter-Holden & Company 268
Practice Productivity, Inc. 340
Preferred Partnerships, Inc. 265
A. H. Robins Company 325, 326
Roche Laboratories 264, 294, 345, 346
Roerig 272, 273, 233
Rome-London Discovery 281
Sherwood's Commercial Broker 333
Smith, Kline & French 295
Squibb & Sons, Inc. 305, 306, 307, 308
United States Navy 339
The Upjohn Company 284
Valley Psychiatric Hospital 322
Waronker, William 330
Weight Watchers of Greater Atlanta 322
Willingway Hospital 334

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets



Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* signifi- cant effect on other normal, necessary intestinal flora.
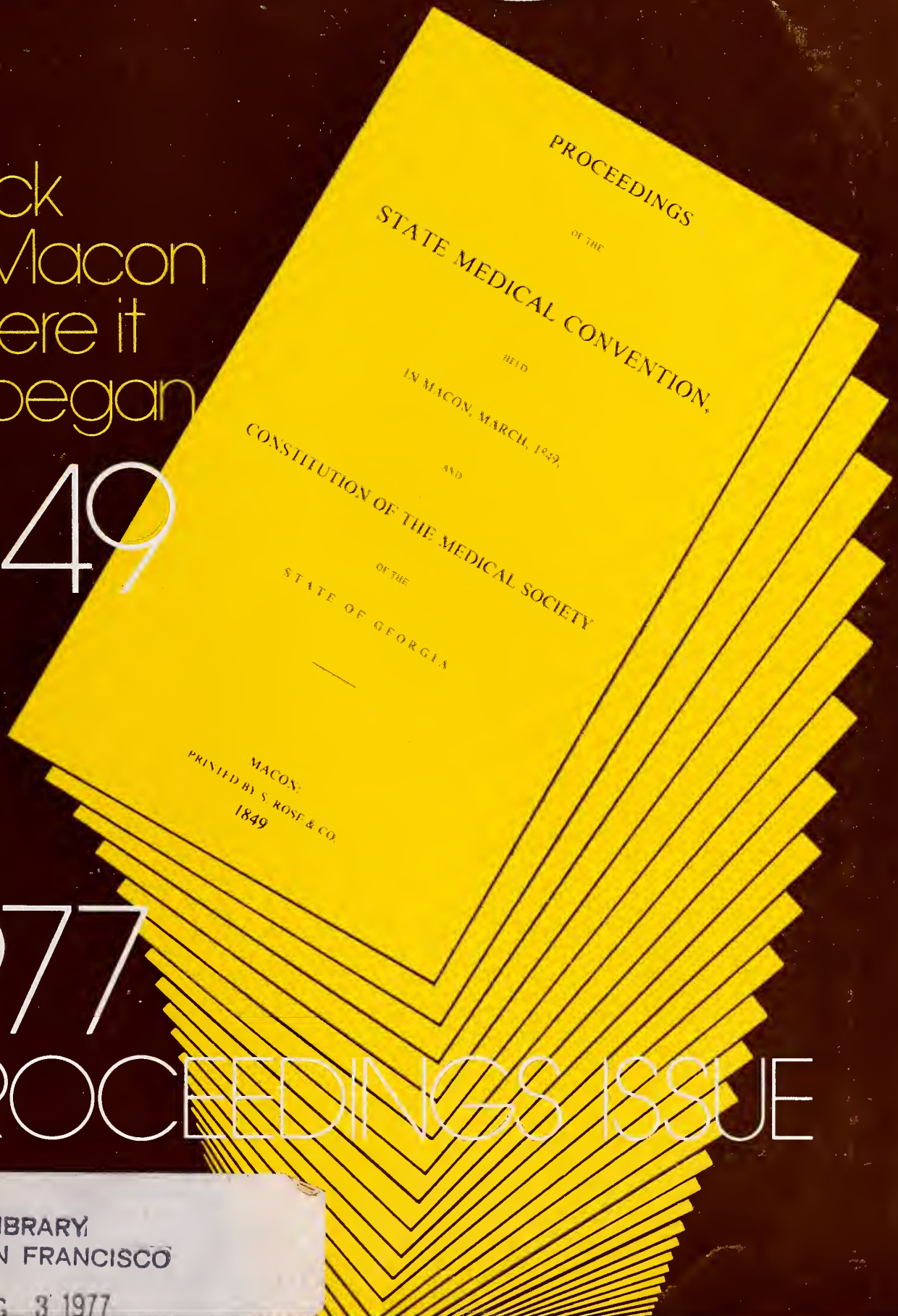
Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

JOURNAL
of the medical association of
georgia
JUNE / 1977

back to Macon where it all began

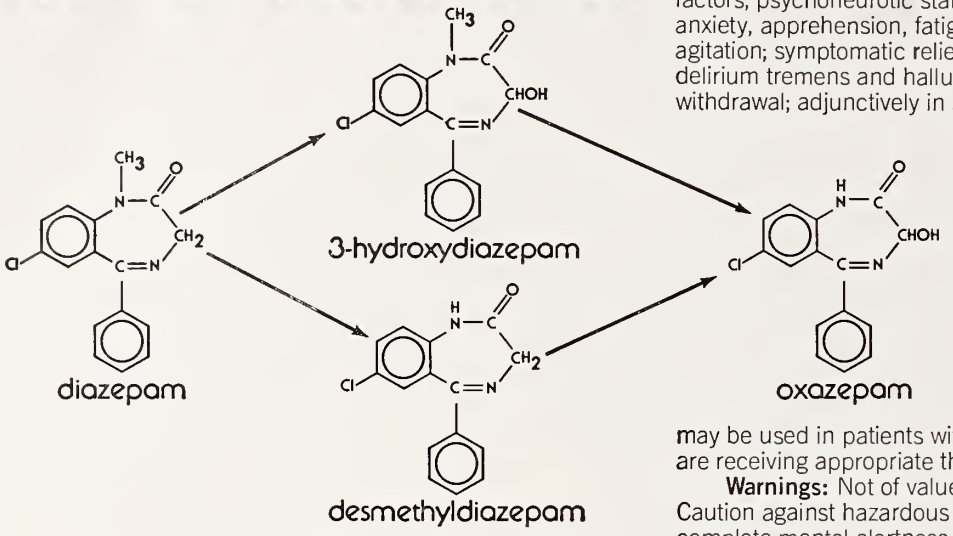
1849



1977 PROCEEDINGS ISSUE

LIBRARY
U.C. SAN FRANCISCO
AUG 3 1977

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CHARLESTON



Ship Watch Villas are for those who love oceanside living, with a touch of elegance. Nestled behind the dune line, almost every one of these vacation homes has a dramatic ocean view, yet is a short walk from all the resort facilities at Kiawah. Prices range from $58,000 to $88,000 for one and two bedroom villas.

KIAWAH ISLAND

The Handsome Homes Of Kiawah Island.

Kiawah is an island of enchanting beauty, blessed with an abundance of wildlife, a balmy climate and close proximity to historic Charleston. With its golf, tennis and potpourri of restaurants, shops and galleries, it is an ideal environment for a permanent or vacation home. For more information, mail the coupon or call 803/559-2777.



Kiawah Island

Kiawah Island Co.
Dept. RMJG1,
Kiawah Island, S.C. 29455

Please send me real estate information on Kiawah.

Name _____ Phone _____

Address _____

_____

Obtain HUD Property Report from developer and read it before signing anything. HUD neither approves the merits of the offering nor the value, if any, of the property.

BRAWNER HOSPITAL, INC.

Established 1910

3180 ATLANTA STREET, S.E.
SMYRNA, GEORGIA 30080
Telephone 404 436-0081



Located in the metropolitan Atlanta area, this psychiatric hospital is staffed by the members of the Center for Interpersonal Studies, P.A. Emphasis is placed on individual and group psychotherapy on an intensive basis. Each patient is assigned a staff psychiatrist who is responsible for the planning of an individualized treatment program, coordination of the assets of the therapeutic community and a continuing liaison with the patient's family and referring physician.

A comprehensive range of services is provided. There are facilities for evaluation and intensive treatment of patients with emotional problems which can be managed in an open psychiatric facility. An accredited high school is located on the hospital grounds and efforts are made to coordinate work with the local school system.

Member of the American Hospital Association and the National Association of Private Psychiatric Hospitals.

Accredited by the Joint Commission on Accreditation of Hospitals.

Mark A. Gould, M.D.
Medical Director

William H. Benson, M.D.
Psychosomatic Medicine

Ronald C. Bloodworth, M.D.
Psychiatry

Herbert Gorod, M.D.
Psychiatry

Karl S. Mihalovits, M.D.
Clinical Director

Jesse R. Peel, M.D.
Psychiatry

Harry Porter, Jr., M.D.
Psychiatry

Frederick W. Huff, Ph.D.
Psychology

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 6

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

OFFICIAL PROCEEDINGS OF THE 1977 ANNUAL SESSION BUSINESS MEETING, APRIL 22-24 AT THE HILTON HOTEL, MACON, GEORGIA

355 Proceedings Index

358 Highlights of the 1977 Annual Session

GENERAL SESSIONS

361 First, Friday, April 22

485 Final, Sunday, April 24

HOUSE OF DELEGATES

365 First, Friday, April 22

390 Second, Saturday, April 23

GaMPAC BRUNCH

389 Summary and Photos

PRESIDENT'S RECEPTION

468 Photos

EDITORIAL

488 Election of MAG Officers

FEATURES

492 President's Letter/1977 Annual Session Successful
Robert E. Perry Jr., M.D.

THE ASSOCIATION

495 New Members

495 Societies

495 Deaths

NEWS

363 Medical Meetings Calendar

402 Test for Physicians Assistants

493 Rural Student Project needs volunteer physicians

493 EMS Newsletter needs articles

493 MAG Speakers Bureau

THE COVER

A reproduction of the first page of the first proceedings of the Medical Association of Georgia. The first convention was held in 1849 in Macon, where 484 people, including delegates, members, Auxiliary and guests, convened this April for the 1977 Annual Session. Cover design by Bob Hamill, Atlanta.

MEDICAL CAREERS

M.D.s
Hospital Administrators
Nursing Home Administrators
Comptrollers
Department Heads
Office Managers
Medical Social Workers
L.P.N.s
Master Social Workers
A.S.C.P.
Directors of Nursing
Physicians' Associates
R.R.A.
X-Ray Technicians
Medical Assistants
Medical Secretaries
A.R.T.
Medical Sales

ALL MEDICAL & PARAMEDICAL

O'KEEFE
PERSONNEL SERVICES

3384 Peachtree Road, N.E.
(404) 266-1153

SHERWOOD'S
PROFESSIONAL PRACTICE SALES

A unique business brokerage service specializing in the confidential presentation of professional practices for sale.

Sherwood's Commercial Brokers

North Center, Suite 201
4319 Covington Highway
Decatur, Georgia 30035
404/288-1330

A unique hospital specializing in treatment of . . .

ALCOHOLISM
DRUG ADDICTION



In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,
Anne & Harry Friedman
Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1977.

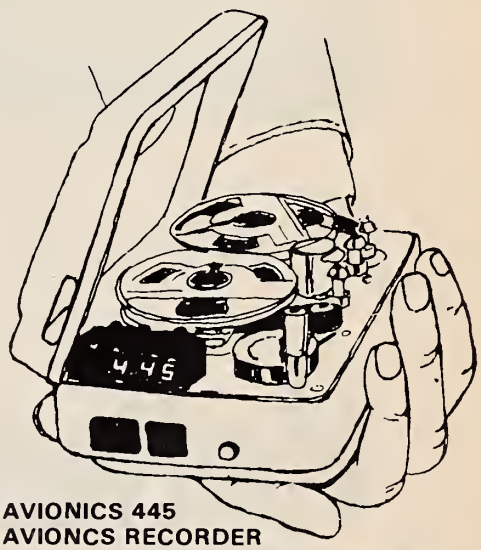
HOLTER MONITOR FREE

HAVE YOUR OWN AVIONICS HOLTER TWO CHANNEL RECORDER IN YOUR OFFICE FREE THROUGH USE OF OUR SERVICE.

SCANNING CENTERS: Boca Raton Florida and Atlanta, Georgia

APPLICATIONS:
Diagnosis of Arrhythmia, Sick-Sinus,
Ischemia, Conduction Defects,
Pacemaker Function,
Correlate drug therapy and assay with 6 hour recording; Make 6 hour recordings part of annual health exams; record 4 to 6 patients per tape.
Holter Monitor your treadmill stress tests and record the following 23 hours.

FEATURES:
The latest state-of-the-art Recorder — FREE!
On-site training of your staff
All tape reports phoned
Mounted reports on your desk within 24 hours
No recording or scanning equipment obsolescense
Highly skilled, experienced Holter technologists scanning your tapes.



AVIONICS 445
AVIONCS RECORDER
1.6 lbs. with battery and recording tape

SEND TO: NON-INVASIVE CARDIAC SERVICES, INC.
P.O. Box 1167, 315 Golfview Drive
Boca Raton, Florida 33432

Name _____

Street _____

City/State _____ Zip _____

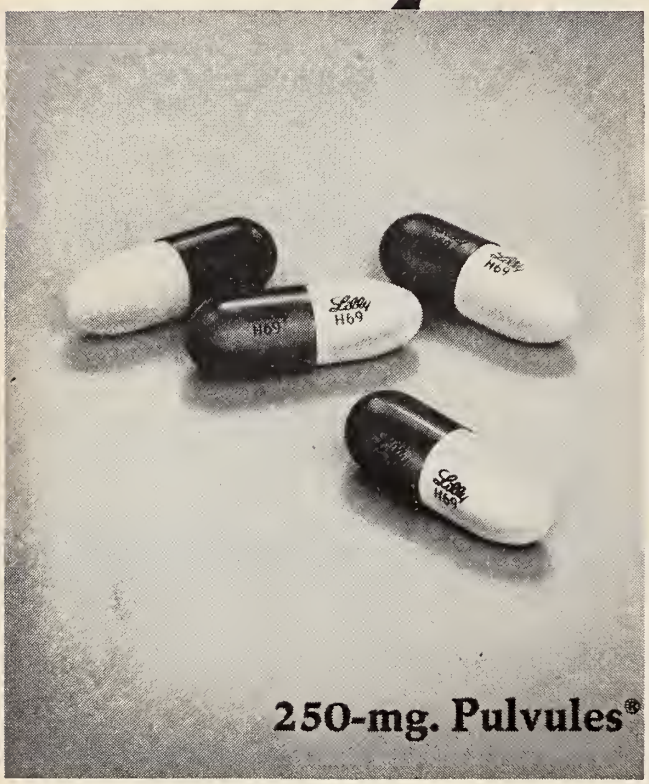
Phone _____

☐ Please send me more information on your scanning service.

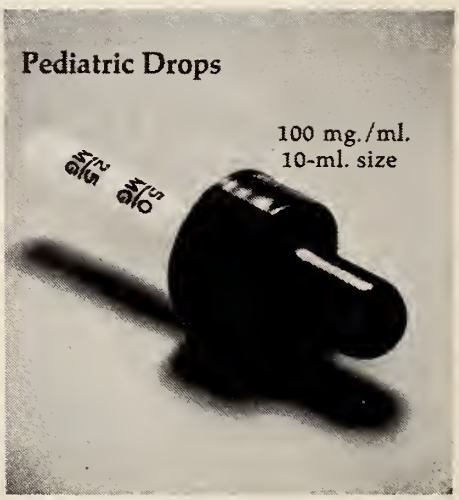
☐ Please phone me with a description of the Free Recorder & Scanning Service.

☐ Have Holter Recorder and am interested in your scanning service.

easy to take







Keflex®
cephalexin

Lilly

500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

Proceedings Index

General Sessions

First Session

Friday, April 22, 1977

Memorial Service . . . 361
List of Deceased Members . . . 361
Presentation of Grants . . . 362
Auxiliary Report . . . 362
Family Physician of the Year Award . . . 362
Fifty-Year Certificates and Pins . . . 362
Civic Endeavor Award . . . 363
Life Membership . . . 363
Certificates of Appreciation . . . 363
Hardman Cup . . . 363
Address by Richard E. Palmer, President of the AMA . . . 363

Final Session

Sunday, April 24, 1977

Installation of Officers . . . 485
Dates and Sites of Future Sessions . . . 487
Attendance Report . . . 487

GaMPAC Brunch

Saturday, April 23, 1977

Guest Speaker . . . 389
Presentation of Awards . . . 389
Photographs . . . 389

House of Delegates

First Session

Friday, April 22, 1977

Attendance . . . 365
Appointment of Committees . . . 366
Nominations for Officers . . . 366

REPORTS

(Reference Committee to which referred in parentheses; NR = Not Referred.)

Association Committees
Scientific Assembly (D) . . . 405
Access to Health Care (NR) . . . 372
Allied Health (NR) . . . 373
Advisory Committee to Auxiliary to MAG (NR) . . . 373
Cancer (NR) . . . 373
Communications (A) . . . 479
Cost Accountability (D) . . . 410
Constitution and Bylaws (C & B) . . . 390
Crawford W. Long Memorial (NR) . . . 374
Disabled Doctors (F) . . . 396
Education (NR) . . . 374
Emergency Medical Services (NR) . . . 375
Health Planning (NR) . . . 376
Joint Georgia Hospital Survey Project (A) . . . 470
Laboratory Quality (D) . . . 408
State Legislation (NR) . . . 377
National Legislation (NR) . . . 380
Liaison Committee on Human Resources (NR) 383
Liaison Committee to Georgia State Medical Association (A) . . . 478
Maternal and Infant Health
Recommendations 1, 2 and 3 (C) . . . 417
Recommendation 4 (D) . . . 416
Medicaid Negotiating Committee (B) . . . 433
Medical Aspects of Sports (D) . . . 412
Medical Practice (B) . . . 431
Medicine and Religion (NR) . . . 384
Membership Insurance (A) . . . 475
Mental Health (NR) . . . 384
Nursing (B) . . . 451
Occupational Health (NR) . . . 384
Physician's Assistants
Majority Report (B) . . . 452
Minority Report (B) . . . 454
Chairman's Report (B) . . . 457
Prison Health Care (NR) . . . 384
Professional Liability Insurance (F) . . . 397
Public Health (D) . . . 414
Subcommittee on Rural Health (NR) . . . 384
School Child Health (NR) . . . 385
Third Party Relations (C) . . . 418
Transfusions and Transplantations (NR) . . . 385
Ad Hoc Committee to Study Business Sessions for Interns, Residents, Students at MAG Annual Sessions (NR) . . . 385
Ad Hoc Committee on Criteria Development for Hospital Utilization Review . . . 386
Ad Hoc Committee to Study the Composite State Board of Medical Examiners (C) . . . 420
Councilors
First District (A) . . . 478
Second District (NR) . . . 369
Third District (NR) . . . 369
Sixth District (NR) . . . 369
Seventh District (NR) . . . 369
Eighth District (NR) . . . 370
Ninth District (NR) . . . 370
Tenth District (NR) . . . 370
Bibb Medical Society (NR) . . . 371
Cobb County Medical Society (NR) . . . 371
DeKalb Medical Society (NR) . . . 371

Floyd-Polk-Chattooga Medical Society (NR) 371
Georgia Medical Society (NR) 372
Medical Association of Atlanta (NR) 371
Muscogee Medical Society (NR) 372
Richmond County Medical Society (NR) 372
Department Reports
Auxiliary to Medical Association of Georgia (A) 463
Georgia Medical Care Foundation (A) 464
Journal of the Medical Association of Georgia (D) 406
Research and Development Division (NR) 386
Officers Reports
President
Annual Report (A) 465
Expanded Representation to House of Delegates (A) 466
First Vice President (A) 459
Second Vice President (A) 480
Council
Affiliate Membership of Mr. A. E. Nolan (A) 460
Amendment to AMA Comprehensive Health Insurance Act (C) 430
Clinical Laboratories (D) 409
Resolution from Society of Anesthesiologists (A) 467
Request for Proposal for PSRO Planning Contracts (D) 403
Budget (F) 398
Medicare Fee Schedule (B) 436
Affiliate Memberships for Camden, Charlton Medical Society (A) 460
Affiliate Membership for DeKalb Medical Society (A) 460
Accounting for CME (D) 407
Secretary (A) 467
Treasurer (A) 461
AMA Delegation (A) 461
Speaker (A) 462
MAG's Quality Assurance Contracts (C) 416
Resolutions
1—Use of Drugs by Optometrists (C) 421
2—Unified Membership (A) 477
3—Cost of Publishing the *Journal of the Medical Association of Georgia* (F) 395
4—Printing and Stationery Services to Membership (A) 465
5—Geographical Fee Determination (C) 422
6—Catastrophic Health Insurance (C) 423
7—Minimum Standards for Health Insurance (C) 423
8—Composite Board of State Medical Examiners (C) 421
9—Medicaid in Georgia (C) 424
10—Preadmissions Screening (B) 436
11—Reforms in the Medicaid and Medicare Laws (C) 424
12—Malpractice Legislation (C) 416
13—Freedom of Choice (B) 436
14—Right of Referendum and Petition (C & B) 394
15—Study and Evaluate Medicaid (C) 429
16—Anti-Smoking Campaign (D) 414
17—Expansion of Family Practice Training (D) 403
18—National Health Insurance Survey (C) 429
19—Redefinition of Associate Membership (C & B) 395
20—Repeal of Chapter Eight Section Two—Unified Membership (A) 477
21—Saccharin (D) 415
22—Health Education in Schools (B) 407
23—County Medical Society Project in Health Education (D) 407
24—Affiliate Membership (A) 460
25—Physician Recruitment by Hospitals (B) 435
26—Unified Membership (A) 478
27—PSRO Planning Contracts (D) 404
28—AMA Membership Opinion Poll Regarding National Life Insurance (B) 430
29—Objection to Saccharin Ban (D) 415
30—Energy Conservation (C) 429
31—Geographical Fee Determination (C) 422
32—Association Finances (A) 481
33—Medical Ethics (A) 480
34—Laboratory Charges (A) 480
35—Investigation of MAG Organization (A) 481
Special Reports
Health Research Group Report Presented to HEW (B) 437

Second Session

Saturday, April 23, 1977

Attendance Report 390

Reports, Reference Committee Recommendations and House of Delegates Actions

Report of Reference Committee on Constitution and Bylaws
Committee on Constitution and Bylaws 390
Resolution 14 394
Resolution 19 395
Report of Reference Committee F
Resolution 3 395
Disabled Doctors 396
Professional Liability Insurance 397
Budget 398
Report of Reference Committee D
Resolution 17 403
Request for Proposal for PSRO Planning Contracts 403
Resolution 27 404
Scientific Assembly 405
Journal of MAG 406
Resolution 22 407
Resolution 23 407
Accounting for CME 407
Laboratory Quality 408
Clinical Laboratories 409
Cost Accountability 410
Medical Aspects of Sports 412
Public Health 414
Resolution 16 414
Resolution 21 415
Resolution 29 415
Maternal and Infant Health 416
Report of Reference Committee C
MAG's Quality Assurance Contract 416
Resolution 12 416
Maternal and Infant Health 417
Third Party Relations 418

Ad Hoc to Study the Composite State Board of Medical Examiners . . . 420
Resolution 8 . . . 421
Resolution 1 . . . 421
Resolution 5 . . . 422
Resolution 31 . . . 422
Resolution 6 . . . 423
Resolution 7 . . . 423
Resolution 9 . . . 424
Resolution 11 . . . 424
Resolution 15 . . . 429
Resolution 18 . . . 429
Resolution 30 . . . 429
Amendment to AMA's Comprehensive Health Care Insurance Act . . . 430

Report of Reference Committee B
Resolution 28 . . . 430
Medical Practice . . . 431
Medicaid Negotiating . . . 433
Resolution 25 . . . 435
Resolution 13 . . . 436
Resolution 10 . . . 436
Medicare Fee Schedule . . . 436
Health Research Group Report . . . 437
Nursing . . . 451
Physician Assistants
Majority Report . . . 452
Minority Report . . . 454
Chairman's Report . . . 457

Report of Reference Committee A
First Vice President . . . 459
Resolution 24 . . . 460
Affiliate Membership for Arthur E. Noland . . . 460
Affiliate Memberships for DeKalb Medical Society 460
Affiliate Memberships for Camden-Charlton County Medical Society . . . 460
Treasurer . . . 461
AMA Delegation . . . 461
Speaker of the House . . . 462
Auxiliary to the MAG . . . 463
Georgia Medical Care Foundation . . . 464
Resolution 4 . . . 465
President . . . 465
Expanded Representation to the House . . . 466
Resolution from Georgia Society of Anesthesiologists . . . 467
Secretary . . . 467
CHAMPUS . . . 469
Joint Georgia Hospital Survey Project . . . 470
Membership Insurance . . . 475
Resolution 2 . . . 477
Resolution 20 . . . 477
Resolution 26 . . . 478
Liaison to the Georgia State Medical Association 478
First District Councilor . . . 478
Communications . . . 479
Resolution 33 . . . 480
Resolution 34 . . . 480
Second Vice President . . . 480
Resolution 32 . . . 481
Resolution 35 . . . 481

ALPHABETICAL INDEX/ITEMS OF SPECIAL INTEREST

Attendance . . . 358, 365, 390, 487
Awards . . . 358, 362, 389
Budget . . . 398
Election Results . . . 483
Future Annual Sessions . . . 359
GaMPAC Brunch . . . 389
Health Research Group Report Presented to HEW 437
Highlights of Annual Session . . . 358, 492
Legislation, National . . . 380
Legislation, State . . . 377
Nader, Ralph, Committee Report . . . (See Health Research Group)
Officers . . . 488
President's Reception . . . 468
Reference Committees
A . . . 459
B . . . 430
C . . . 416
C & B . . . 390
D . . . 403
F . . . 395

Highlights of the 1977 annual session

THE 1977 ANNUAL SESSION of the Medical Association of Georgia was held at the Hilton Hotel in Macon, April 22-24. The total attendance, including delegates, members, Auxiliary and guests, was 484.

More people attended the Annual GaMPAC Brunch than ever before. Details and photos are on page 389.

Saturday morning, April 21, MAG held a seminar on professional liability.

All resolutions and reports presented to the 1977 House of Delegates and all House actions follow these highlights.

Awards

James C. Dismuke of Adel was presented the Family Physician of the Year Award; Nicholas E. Davies of Atlanta received the Civic Endeavor Award, and the Hardman Cup was given to Andre Nahmias of Atlanta.

Officers

Robert E. Perry Jr. of Brunswick was installed as President and Carson B. Burgstiner of Savannah was installed as President-Elect.

Other officers for 1977-78 are: Fleming L. Jolley of Atlanta, Immediate Past President; Earnest C. Atkins of Decatur, Secretary; James H. Sullivan of Columbus, Treasurer; Milton I. Johnson of Macon, First Vice President; L. Newton Turk III of Atlanta, Second Vice President; L. C. Buchanan of Decatur, Speaker of the House; Jack F. Menendez of Macon, Vice Speaker; Joe C. Stubbs of Valdosta, Chairman of the Board of Directors, and Jack A. Raines of Columbus, Vice Chairman of the Board.

AMA delegates are: C. Emory Bohler of Brooklet, and F. William Dowda of Atlanta. Alternate delegates: F. G. Elderidge of Valdosta; Charles D. Hollis of Albany.

Health costs

MAG's Committee on Cost Accountability made several recommendations which the House adopted with modifications. Among these was the recommendation calling for MAG to support establishment of community meetings on health costs. These meetings would serve as forums to educate both providers and the public. Participants would be providers, media representatives, labor and management.

The Committee also recommended that insurance carriers be urged to eliminate first-dollar coverage and encourage the use of deductibles and co-insurance.

Single reinbursement area

MAG will ask the Bureau of Health Insurance to conduct a fee-differential survey in Georgia for determining the possibility of having a single reinbursement area for the state. The idea is to eliminate geographic fee discrimination inherent in the use of four areas.

Drug use by optometrists

The House approved a resolution directing MAG to oppose any legislation which would authorize optometrists to diagnose or treat eye diseases, perform any type of surgery, or use drugs or medications in any form, except under the direct supervision of a licensed M.D.

Physicians assistants

The House affirmed the obligation of physicians to report any misuse of PAs to the Composite State Board of Medical Examiners or other proper authorities. The House also took a firm stand in opposition to the independent licensure of PAs. A resolution will go to the AMA House of Delegates expressing MAG's concerns over misuse of PAs.

National health insurance

The policy adopted by the 1976 House was reaffirmed by the 1977 House, that being that MAG opposes *any* form of national health insurance. The Georgia delegation to the AMA was instructed to ask for an AMA membership opinion survey on NHI, with the understanding that if a majority of members are in opposition, the AMA would be required to withdraw support for its own NHI bill.

PSRO

The Association's position on PSRO was reviewed and its position was reaffirmed: MAG will apply for a planning contract 15 days before the deadline (whenever that might be) for priority consideration to physician groups. The Board of Directors, in consultation with legal counsel, will determine the appropriate applicant for the contract.

Medicaid

Revised physician reinbursement policies will soon be distributed by Medicaid. A new policy was adopted by the House in which each physician is urged to make his own decision on participation in Medicaid after carefully reviewing the revision and the Statements of Participation.

Hospital medical staffs

If requested, the MAG Committee on Medical Practice and the Association's legal counsel can assist hospital medical staffs in reviewing staff bylaws to decide if they were written in so as not to jeopardize the best interest of staff members.

Hospital pre-admission screening

A resolution calling for MAG to investigate various hospital admission screening mechanisms was rejected by the House on the basis that there is no evidence that pre-admission screening would improve the quality of medical care or reduce costs to the patient.

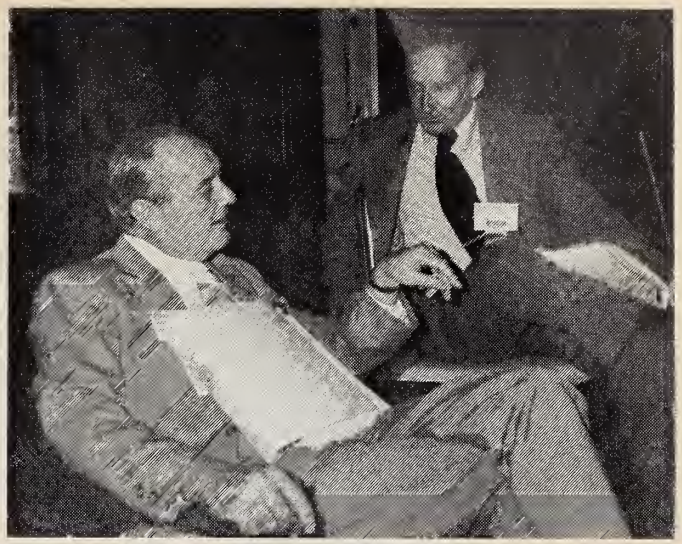
District elections by mail

A bylaws change adopted by the House makes it possible for district medical societies to conduct elections by mail ballot. Mechanisms for conducting such elections must first be approved by the MAG Board of Directors.

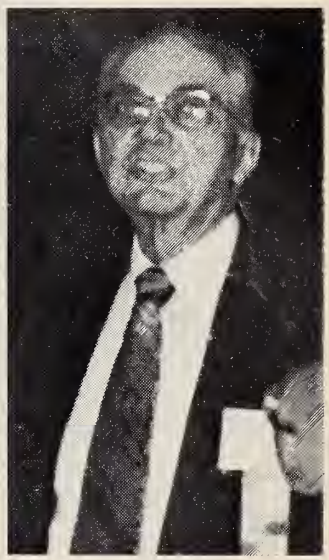
Future meetings

The dates and sites of future Annual Business Sessions are:

1978 (April 14-16) Jekyll Island Holiday Inn
1979 (April 20-22) DeSoto Hilton, Savannah
1980 (April 25-27) Hilton International Hotel, Atlanta

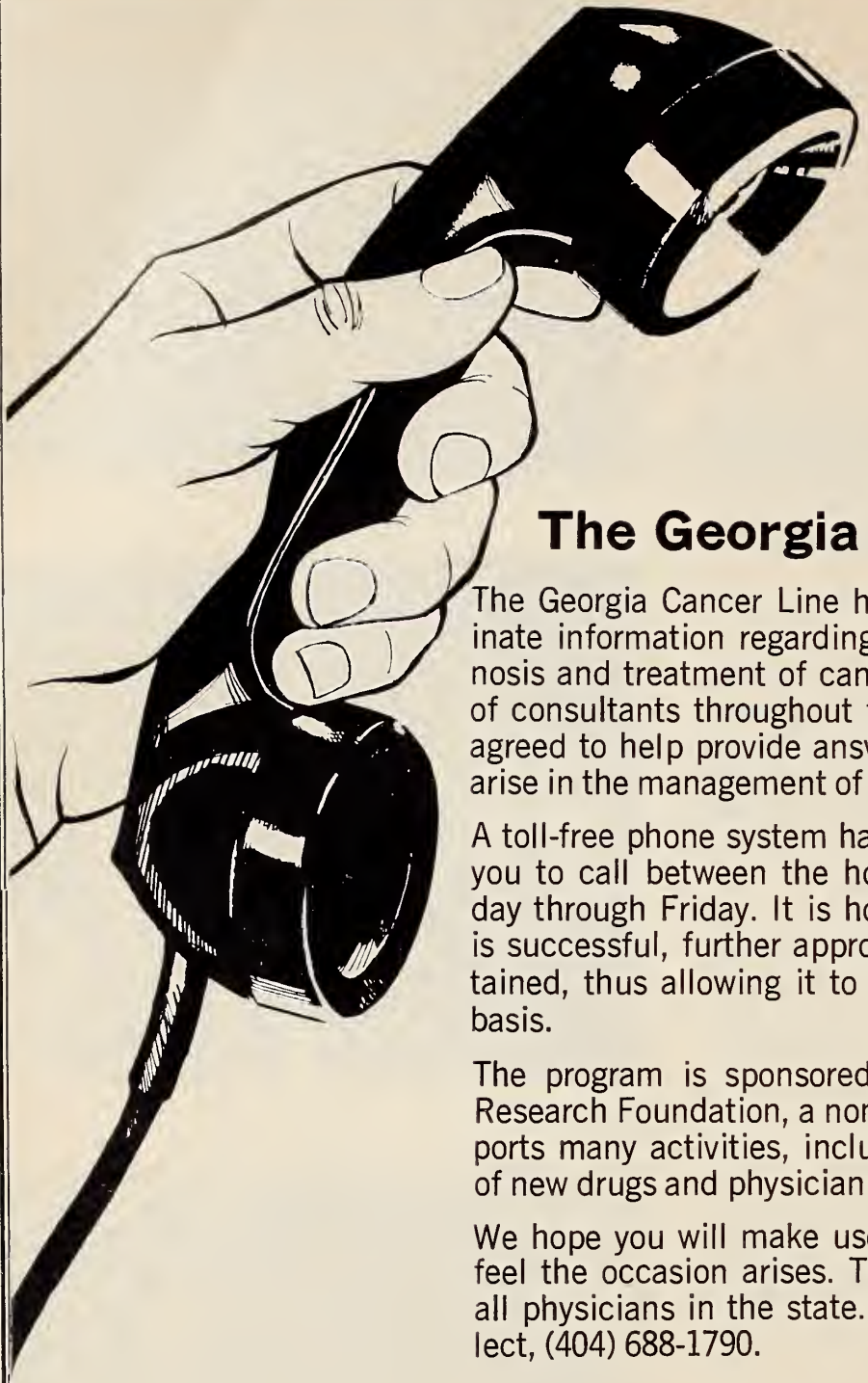








AMA President, Dr. Richard Palmer, and Dr. Louis Felder; MAG Past President, Dr. W. C. Mitchell; Past President, Dr. L. George Alexander; Past Presidents, Dr. John T. Mauldin and Dr. Rhodes Haverty.



The Georgia Cancer Line

The Georgia Cancer Line has been developed to disseminate information regarding recent advances in the diagnosis and treatment of cancer. We have enlisted a group of consultants throughout the state of Georgia who have agreed to help provide answers to questions which might arise in the management of cancer cases.

A toll-free phone system has been set up which will allow you to call between the hours of 9 am and 5 pm, Monday through Friday. It is hoped that if this pilot program is successful, further appropriate sponsorship can be obtained, thus allowing it to be continued on a permanent basis.

The program is sponsored by the Southeastern Cancer Research Foundation, a non-profit organization which supports many activities, including clinical research, testing of new drugs and physician education projects.

We hope you will make use of this system whenever you feel the occasion arises. The Cancer Line is available to all physicians in the state. All you have to do is call collect, (404) 688-1790.

Sponsored by
The Southeastern Cancer Research Foundation
P.O. Box 54777, Atlanta, Ga. 30308
(404) 688-1790

Call Collect

(404) 688-1790





Dr. Robert E. Perry Jr. presents the Civic Endeavor Award to Dr. Nicholas E. Davies, as Dr. Fleming Jolley looks on; Dr. Milton F. Bryant Jr. presents a certificate of appreciation to his wife, Atchie, for her fine work with the Auxiliary.

MAG First General Session

1977 Annual Session Business Meeting Friday, April 22, 1977

THE FIRST GENERAL SESSION of the 1977 Annual Business Meeting (House of Delegates) of the Medical Association of Georgia was called to order by President Fleming L. Jolley, M.D. of Atlanta at 9:00 a.m. in the Grand Ballroom at the Hilton Hotel, Macon, Georgia, on April 22, 1977.

Dr. Jolley called on Harrison L. Rogers Jr., M.D., J. Dan Bateman, M.D., and C. Emory Bohler, M.D., to lead the assembly in the singing of the National Anthem.

Dr. Jolley extended an official welcome to everyone present and called upon Rupert H. Bramblett, M.D., of Cumming for the invocation.

President Jolley called on Ernest C. Atkins, M.D., MAG Secretary, to read the names of MAG members who had died since the 1976 Annual Session. They are as follows:

MAG Deceased Members

Osler A. Abbott, Atlanta, November 3, 1976
J. Fred Adams, Montezuma
A. J. Aselmeyer, Atlanta, November 2, 1975
Carl C. Aven, Marietta, June 1, 1976
Mercer Blanchard, Columbus, August 14, 1976
F. Bert Brown, Savannah, April 20, 1976
Charles K. Bush, Atlanta, October 8, 1976
L. H. Campbell, Macon, March 2, 1977
J. L. Carpenter, Atlanta, May 1, 1976
Ben H. Clifton, Atlanta, June 26, 1976
Grady N. Coker (Past Pres.), Canton, February 23, 1977
William L. Cousins, Tucker, June 6, 1976
Charles T. Cowart, LaGrange, September 30, 1976
Charles W. Daniels, Atlanta, January 25, 1976
V. L. Darby, Waycross
Bon M. Durham, Americus
Charles A. Eberhart, Atlanta, February 25, 1977
Charles B. Fulghum, Milledgeville, May 7, 1976
Carlos Garcia-Rivera, Milledgeville, December 6, 1976
Thomas N. Goodwin (Past Pres.), Augusta, March 25, 1977
James M. Hicks, Brunswick, May 15, 1976
Herman D. Jones (Ph.D.), Auburn, Alabama, March 6, 1977
Willis P. Jordan Sr., Columbus
Robert P. Kelly, Atlanta, December 19, 1976
George F. Klugh, North Carolina, August 14, 1976
Homer H. Lancaster, Gainesville, September 16, 1976
Earle Lewis, LaGrange, November 30, 1976
J. C. Morgan, West Point
W. A. Newman, Macon
Robert B. Nuttall, Mableton
B. G. Owens, Valdosta, October, 1975
J. V. Pierotti, Atlanta, January 17, 1977
J. W. Rhea, Columbus
Robert C. Robbins, Marietta, April 9, 1976
Ben A. Rutledge, Atlanta, October 19, 1976
Walter A. Schimmel, St. Simon's Island, May 25, 1976
J. Gregg Smith, Forsyth

William J. Smith, Brunswick
W. R. Snelling, Columbus, March 15, 1976
Martin Van Buren Teem, Marietta, September 16, 1976
Frank Veverka, Columbus, February 14, 1977
E. J. Virusky, Baxley
Edward B. Waxler, Waycross, March 28, 1977
David Wolfe, Dublin, October 13, 1976
Lloyd Yeargin, Dalton, May 24, 1976.

Following the memorial service, Dr. Jolley introduced Dr. Hugh F. Smisson, M.D., President of the Bibb County Medical Society, who in turn introduced Mr. Buckner F. Melton, Mayor of the City of Macon and both Dr. Smisson and Mayor Melton extended official greetings from the city and from the host county society.

Introduction of Distinguished Guests

President Jolley introduced several distinguished guests: Ms. Barbara Eich, Charles S. McJunkin, Robert Berlin, Alex Kemp, Morris M. Bradley, Fred Higginbotham, Robert Thompson, Ted Snyder, David B. Poythress, Ms. Betty Golden, William C. Davis, Roger T. Lane, Rev. Daniel Rees Thomas Jr., Mrs. Betty Shannon Daniels, Alan B. Sams, and J. D. Gilland, M.D.

At this point President Jolley introduced Mrs. Milton F. Bryant Jr. of Atlanta, President of the Auxiliary to the Medical Association of Georgia. Mrs. Bryant gave a report on the activities of the Auxiliary during the past year and introduced a special guest, Mrs. Chester L. Young, President-Elect of the Auxiliary to the American Medical Association. Mrs. Young extended greetings from the AMA Auxiliary and gave a brief report on the activities of that organization.

Mrs. Bryant introduced Miss Terry Leyel, President of the Health Career Clubs, who made a brief report on their activities during the previous year.

Dr. Jolley called on Robert E. Perry Jr. of Brunswick, President-Elect of MAG, who in turn spoke briefly on the theme of his incoming administration, stressing unity as the cornerstone of that theme.

President Jolley then introduced several past presidents of the Medical Association of Georgia:

Dawson Allen, M.D., Milledgeville
Luther H. Wolff, M.D., Columbus
Milford B. Hatcher, M.D., Macon
J. G. McDaniel, M.D., Atlanta
George H. Alexander, M.D., Forsyth
John T. Mauldin, M.D., Atlanta
Charles R. Andrews, M.D., Canton
John Kirk Train Jr., M.D., Savannah
F. G. Eldridge, M.D., Valdosta
William C. Mitchell, M.D., Smyrna
F. William Dowda, M.D., Atlanta
C. Emory Bohler, M.D., Brooklet
J. Rhodes Haverty, M.D., Atlanta
David A. Wells, M.D., Dalton

Presentation of Grants

Dr. Jolley presented the two Georgia medical schools unrestricted grant monies in the form of an AMA-ERF check raised by contributions from the physicians and auxiliary during the previous year. Dr. Jolley presented the checks as follows: to Dr. Joseph T. Bailey, Associate Dean for Clinical Services of the Medical College of Georgia, a check in the amount of $8,329.97, and to Dr. Bernard Hallman, Associate Dean, Emory University School of Medicine, a check in the amount of $8,222.02.

Family Physician of the Year Award

MAG presents an annual award to the family physician of the year and calls upon the Board of Directors of the Georgia Academy of Family Physicians to select the recipient of this award.

Dr. Jolley asked H. Gordon Davis, M.D., of Sylvester, President of the Georgia Academy, to present the award this year to James C. Dismuke, M.D., of Adel.

Editorial Note—The following awards were announced in the printed program distributed to the members present:

Fifty Year Certificates and Pins (Members who have been in practice for fifty years): Thomas M. Adams, Montezuma; Oliver Arteaga, Atlanta; John



Auxiliary Registration

B. Avera, Brunswick; Feltz C. Davis, Macon; Walter R. Garner, Gainesville; Willard R. Golsan, Macon; E. L. Graydon, Atlanta; Albert Worth Hobby, Atlanta; Hartwell Joiner, Gainesville.

Mason I. Lowance, Atlanta; Joseph C. Massee, Atlanta; James G. McDaniel, Atlanta; Samuel W. Perry, Atlanta; William L. Pomeroy, Waycross; Lewis L. Rawls, Macon; Paul T. Scoggins, Commerce; Lucas N. Turk Jr., Homer.

Life Membership (Members who have supported the organization of medicine for at least 25 years and who are 70 years old): Belford C. Blaine, Atlanta; Lester A. Brown, Atlanta; Howard M. Coe, Brunswick; W. P. Harbin Jr., Rome; J. R. S. Mays, Macon; Lila Bonner Miller, Atlanta; Joyce F. Mixson, Valdosta; C. James Roper, Jasper; John Van Duyn, Columbus; Hoke Wammock, LaGrange.

Certificates of Appreciation (Awarded to members who have been active in the affairs of the Association): Earnest C. Atkins, M.D., Atlanta; J. Gordon Barrow, M.D., Atlanta; Wilbur E. Baugh, M.D., Milledgeville; Linton H. Bishop, M.D., Atlanta; Wiley S. Black, M.D., Gainesville; Milton F. Bryant Jr., M.D., Atlanta; Carson B. Burgstiner, M.D., Savannah; Nicholas E. Davies, M.D., Atlanta; Thomas G. Douglass, M.D., Augusta; James C. Dudley, M.D., Americus; Ronald F. Galloway, M.D., Augusta; John W. Garland III, M.D., Gainesville; J. Winston Huff, Atlanta; Milton I. Johnson, M.D., Macon.

Fleming L. Jolley, M.D., Atlanta; William D. Logan, M.D., Atlanta; Jack F. Menendez, M.D., Macon; Frank R. Miller, M.D., Thomasville; George E. Mixson, M.D., Valdosta; Hon. Thomas B. Murphy, Breman; Hon. Bobby E. Parham, Milledgeville; Robert E. Perry Jr., M.D., Brunswick; Edwin C. Pound, M.D., Atlanta; Jack A. Raines, M.D., Columbus; Roger R. Rowell, M.D., Decatur; James H. Sullivan, M.D., Columbus.

Civic Endeavor Award

The Civic Endeavor Award is a special award designed to honor those physicians active in civic affairs. The recipient of the award is selected by a secret committee which evaluates nominations made by the county medical societies. Dr. Jolley called on Robert Perry, M.D., President-Elect, who announced that the recipient of the Civic Endeavor Award was Nicholas E. Davies, M.D., of Atlanta.

Hardman Cup

The Hardman Cup is presented for discovery or solution of an outstanding problem in public health or to one who has made a significant discovery or contribution to the science of medicine. Dr. Jolley announced that the Hardman Cup Award would go to Andre J. Nahmias, M.D., for his contributions to the clinical, epidemiological, urological and immunological aspects of herpes simplex virus infection.

Guest Speaker

Dr. Jolley introduced Richard E. Palmer, M.D., President of the American Medical Association, who addressed the First General Session of the 1977 MAG Annual Session. Following Dr. Palmer's address, President Jolley made several brief announcements and adjourned the first General Session at 10:20 a.m.

Medical Meeting Calendar

JULY

12-15—*Atlanta;* **MEDICAL OFFICE MANAGEMENT INSTITUTE (FOR MEDICAL OFFICE MANAGERS);** Contact: Conomikes Assoc., Inc., 4270 Promenade Way, Marina del Rey, CA 90291, PH: 213/823-4661.

18-22—*Jekyll Island;* **TAX, RETIREMENT, AND ESTATE PLANNING AND FINANCIAL INVESTMENTS;** Category 2 Credit; Contact: Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

30—*Macon;* **EMERGENCIES IN FAMILY PRACTICE** (Sponsored by Family Practice Residency Program) Category 1 Credit; Contact: Don Purdy, MD, 784 Spring St., Macon 31201.

AUGUST

1-5—*Myrtle Beach, SC;* **5TH ANNUAL BEACH SYMPOSIUM;** Category 1 Credit; contact: Bowman Gray School of Medicine, 300 S. Hawthorne Rd., Winston-Salem, NC 27103.

15-19—*Atlanta;* **ACP-MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM IV;** Category 1 Credit; Contact: American College of Physicians, 4200 Pine St., Philadelphia 19104.

15-20—*Cashiers, NC;* **SMOKY MOUNTAIN SUMMER SEMINAR;** Category 1 Credit; Contact: Assoc. Dean of CME, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1676.

how do others avoid tax headaches? your CPA knows.



Certified Public Accountants (CPAs) are professionals authorized by law to perform the full range of accounting services... from preparation of individual tax returns to expression of formal opinions on the most sophisticated financial statements. Qualified by requirements of the State of Georgia for education, examination, and experience, the CPA is a valuable source of professional counsel and guidance, analysis, and judgment. When it comes to preparing tax returns and tax planning, he naturally has a broad view. He tends to see things as a whole, not just piecemeal. He provides overall tax planning.

For tax return service consult your Yellow Pages under "Accountants—Certified Public."

GEORGIA CPA SOCIETY

GEORGIA SOCIETY OF
CERTIFIED PUBLIC ACCOUNTANTS

4105A

First Session House of Delegates

Friday, April 22, 1977

THE FIRST SESSION of the House of Delegates was called to order by Speaker L. C. Buchanan at 10:30 a.m. in the Grand Ballroom, Hilton Hotel, Macon, Georgia, on Friday, April 22, 1977.

The Speaker extended his greetings to all delegates and briefly outlined the responsibilities of the House and the procedure to be followed during the three sessions of the House on April 22, 23 and 24, 1977.

The Speaker called for a report of the delegates in attendance. Hugo S. Moreno, M.D., of East Point, Chairman of the Credentials Committee reported that there were 133 registered delegates representing 38 component county medical societies present and accordingly announced that a quorum of the House was present.

Attendance

Stanley P. Aldridge, Joseph M. Almand Jr., Thomas J. Anderson Jr., William Anderson, Jimmy R. Asbell, James L. Askew, Phil C. Astin Jr., Joseph P. Bailey, William E. Barfield Sr., Dan J. Bateman, Harvey Beall, Sidney A. Bell, H. Duane Blair, Alan C. Bleich, Augustus F. Bloodworth, Jerome B. Blumenthal, Charles Emory Bohler, J. G. Bohorfoush, Claud A. Boyd Jr., David M. Boyette, Rupert H. Bramblett, James N. Brawner III, L. C. Buchanan, Carson B. Burgstiner, E. Napier Burson Jr.

Albert A. Carr, Ted D. Cash, Joe Caskin, Joseph T. Christmas, Remer Y. Clark Jr., Surgeon William Clark Jr., Robert P. Coggins, David M. Cohen, Marvyn D. Cohen, Richard W. Cohen, Lamar Collie III, William C. Collins, Carl L. Crawford, Leon E. Curry, David E. Dalrymple, Floyd E. Davis, R. Carter Davis Jr., J. H. Deaton, John I. Dickinson, F. W. Dowda, Daniel R. Duke, Leonard C. Durrence Jr.

Julius Ehik, F. G. Eldridge, E. C. Evans, R. J. Filson, Lucien A. Flint, G. Lester Forbes, John G. Forshner, Henry A. Foster, Lawrence L. Freeman, Ronald A. Freeman, Ronald Frost Galloway, Norman P. Gardner, John W. Garland III, Cyler D. Garner, Frank L. Gibson, Stewart D. Gilbert, Joseph L. Giradeau, Michael A. Glucksman, Milton S. Goldman, Samuel M. Goodrich, Walter S. Gresham, Joe L. Griffith, Richard A. Griffin III.

O. Emerson Ham Jr., H. Hilt Hammett Jr., Carl V. Hancock Jr., Timothy Harden Jr., Charles E. Harrison Jr., Clyde C. Harrison Jr., John Rhodes Haverty, John P. Heard, Irving Hellenga, Hugh O. Hodges, Charles D. Hollis Jr., William R. Howard, William Hugher Jr., Phillip A. Israel, Joseph M. Jackson, Jimpsey B. Johnson, Julius T. Johnson, Frank M. Johnston, James C. Joiner III, Fleming L. Jolley, W. Daniel Jordan.

James A. Kaufman, C. Peter Lampros, Bob G. Lanier, James Moultrie Lee, Kuo Lam Lee, James R. Logan, William Dewey Logan Jr., Thomas N. Lumsden, Ahmad A. Mahayni, Donald H. Manning, James Hunt Manning, R. Mathison, Richard C. Mattison, Bob R. Maughon, Edwin A. Mayo, Bradwell R. McAllister, Arnold McAlpin, John R. McCain, John M. McCoy, V. W. McEver Jr., Lamar S. McGinnis Jr., Donald J. McKenzie.

Jack F. Menendez, George W. Merritt, Cecil L. Miller, Edmund M. Molnar, W. W. Moore, Hugo S. Moreno, Tobby S. Morgan, Joseph V. Morrison Jr., R. J. Moyer, A. D. Muse Jr., Joe L. Nettles, Harvey M. Newman, Bruce C. Newson, Millege C. Newton, Robert W. Oliver Jr., James J. Oosterhoudt, J. Gary Palmer Jr., J. Lee Parker, Larkus Pershell, Harry Porter Jr., Stuart H. Prather Jr., Bill Purcell, Robert A. Pumpelley.

Keith A. Quarterman Jr., Jack A. Raines, Harold S. Ramos, Walter J. Revell, Charles J. Rey Jr., Charles R. Richardson, Frank T. Robbins, Harrison L. Rogers Jr., J. Roy Roland, T. A. Sappington, J. K. Schellack, Henry D. Scoggins, Charlie O. Sennett Jr., Robert W. Simmons, James M. Skinner, Hugh F. Smisson, James H. Smith, Luther J. Smith II, Patton P. Smith, R. L. Smith, Robley D. Smith, Richard H. Smoot, William B. Spearman, Robert L. Starling, Dan B. Stephens, Carlos A. Stuart, Joe C. Stubbs, James H. Sullivan.

Eloise B. Therman, Luther M. Thomas Jr., Hugh S. Thompson Jr., Barrie H. Thrasher Jr., Thomas L. Tidmore Jr., Ralph A. Tillman, Charles E. Todd Jr., John P. Tucker, L. Newton Turk III, Roy W. Vandiver,

William C. Waters, Alexander H. Weaver, H. E. Weems Jr., John A. Wells, Robert E. Wells, James Whitaker, Douglas G. Whitney, Chan White, Betty B. Wray, Charles H. Wray.

Speaker Buchanan thanked the Chairman of the Credentials Committee for his report; he then presented Ronald F. Galloway, M.D., Augusta, Vice Speaker of the House of Delegates, and explained in some detail the procedures to be followed for the consideration of business that would come before the House of Delegates for the remainder of this session.

Appointment of Committees

The Speaker announced the appointment of the House of Delegates Credentials Committee, Tellers Committee and Reference Committees as follows:

CREDENTIALS COMMITTEE: Hugo S. Moreno, East Point, Chairman; Jimmy R. Asbell, Macon; Joseph T. Christmas, Vienna.

TELLERS COMMITTEE: Ralph A. Tillman, Decatur, Chairman; Claud A. Boyd, Augusta; J. Anderson, Atlanta; Thomas N. Lumsden, Clarksville.

REFERENCE COMMITTEE A: Robert W. Oliver, Dublin, Co-Chairman; Luther M. Thomas Jr., Augusta, Co-Chairman; Michael A. Glucksman, Brunswick; O. E. Ham, Savannah; William C. Waters III, Atlanta; Roy W. Vandiver, Decatur.

REFERENCE COMMITTEE B: Ronald F. Galloway, Augusta, Chairman; James H. Smith, Rome, Vice Chairman; Frank W. McKinnon, Marietta; James A. Kaufman, Atlanta; Keith A. Porterman Jr., Atlanta; Alexander H. S. Weaver, Macon.

REFERENCE COMMITTEE C: Jack A. Raines, Columbus, Chairman; John P. Heard, Decatur, Vice Chairman; Robert F. Coggins, Marietta; Albert A. Carr, Augusta; H. Hilt Hammett Jr., LaGrange; Franklin P. Bousquet Jr., Savannah.

REFERENCE COMMITTEE D: Lamar S. McGinnis, Decatur, Chairman; Marvyn D. Cohen, Columbus, Vice Chairman; J. Moultree Lee, Savannah; Jimpsey B. Johnson, Augusta; William C. Collins, Atlanta; Jack F. Menendez, Macon.

COMMITTEE ON CONSTITUTION AND BY LAWS: F. G. Eldridge, Valdosta, Chairman; David M. Boyette, Albany, Vice Chairman; Robert Moy, Queensboro; Edmund M. Molnar, Columbus; L. Austin Flint, Canton; William D. Spearman, Atlanta.

REFERENCE COMMITTEE F: H. Duane Blair, Decatur, Chairman; G. Lester Forbes, Atlanta; Stuart H. Prather Jr., Augusta; J. Gary Palmer Jr., Marietta; Rupert H. Bramblett, Cumming; Cyler C. Garner, Gordon.

The Speaker announced that the proceedings of the 1976 Annual Session had been published in the June 1976 issue of the *Journal of the Medical Association of Georgia* and called for any corrections that should be made. Delegate W. Daniel Jordan of Atlanta moved to correct the proceedings of the 1976 meeting as follows:

On page 226, House of Delegates Action—Delegate Jordan moved to amend the Reference Committee recommendation by addition of the words "thereby declaring participation in PSRO to be ethical." This failed by a tie vote. This correction was adopted.

Delegate Fleming L. Jolley moved to correct the proceedings of the 1976 meeting on page 257 of the June 1976 issue of the *JMAG* to show that part one of item five of the Constitution and Bylaws Committee report by the Reference Committee on Constitution and Bylaws was adopted. This correction was adopted.

On motion made and seconded, it was voted that these minutes be approved as published and corrected.

Nominations

Speaker Buchanan called on the House to proceed with nominations of officers, AMA delegates and alternates, councilors and vice-councilors. He reminded the House that the election would be held on Sunday morning with the voting hours between 7 a.m. and 9 a.m., with ballots being provided by the Credentials Committee.

The Speaker asked for nominations for the office of MAG President-Elect and the following nomination was made:

PRESIDENT-ELECT: Carson B. Burgstiner, Savannah, was nominated by F. G. Eldridge, Valdosta, who had assumed the floor when yielded by delegate O. E. Ham of Savannah. Dr. Burgstiner's candidacy was seconded by David A. Wells, Milton I. Johnson, Harrison L. Rogers Jr., J. Dan Bateman, C. Emory Bohler, H. Hilt Hammett and James A. Kaufman. There being no further nominations for the office of President-Elect, the nominations were closed.

SECOND VICE PRESIDENT: L. Newton Turk III, Atlanta, was nominated for the office of Second Vice President by William Huger. Dr. Turk's candidacy was seconded by Joe Stubbs, William C. Waters, Luther Thomas and J. Dan Bateman. There being no further nominations for the office of Second Vice President, the nominations were closed.

TREASURER: Nominations for the office of Treasurer were received to fill the unexpired term (one year) of Carson B. Burgstiner, who vacated that office to accept the nomination for President-Elect. James H. Sullivan, Columbus, was nominated for the office of Treasurer by Bob R. Maughon. Dr.

Sullivan's candidacy was seconded by Richard Griffin, William W. Moore, J. W. Chambers, Stuart Prather and Luther Wolff. There being no further nominations for the office of Treasurer, the nominations were closed.

SPEAKER: L. C. Buchanan, Decatur, was nominated for the office of Speaker of the House of Delegates by Harrison L. Rogers Jr., as the floor was yielded to him for this purpose by Stanley Aldridge. Dr. Buchanan's candidacy for the office of Speaker was seconded by Michael Glucksman, E. Emory Bohler, Fleming L. Jolley, Jack Raines and Joseph T. Bailey. There being no further nominations for the office of Speaker, the nominations were closed.

VICE SPEAKER: Jack F. Menendez, Macon, was nominated for the office of Vice Speaker by Hugh Smisson. Dr. Menendez's candidacy was seconded by Charles Hollis, T. A. Sappington, Rupert Bramblett and Charles Harrison. There being no further nominations for the office of Vice Speaker, the nominations were closed.

AMA DELEGATES: Speaker Buchanan called for nominations for Delegates to the American Medical Association. He observed that the term of all new delegates would begin on January 1, 1978. For the AMA Delegate seat currently held by C. Emory Bohler, Brooklet, C. Emory Bohler was nominated by F. G. Eldridge. Seconding the nomination was Robert E. Perry, Joe Stubbs, Henry Scoggins and Joe Christmas. There being no further nominations for this office, the nominations were closed.

For the AMA Delegate seat currently held by F. William Dowda, Atlanta, F. William Dowda was nominated by Harrison L. Rogers Jr. Seconding this nomination were Robert Coggins, H. Hilt Hammett and Bob R. Maughon. There being no further nominations for this office, the nominations were closed.

AMA ALTERNATE DELEGATES: For the AMA Alternate Delegate seat currently held by Charles D. Hollis, Albany, Charles D. Hollis was nominated by Morton Boyette. Seconding this nomination was Joe Wilson. There being no further nominations for this office, the nominations were closed.

For the AMA Alternate Delegate seat currently held by F. G. Eldridge, Valdosta, F. G. Eldridge was nominated by J. W. Chambers. Seconding this nomination were F. William Dowda and Henry Scoggins. There being no further nominations for this office, the nominations were closed.

Councilors and Vice Councilors

Dr. Buchanan announced the results of the election for Councilor and Vice Councilor as conducted by the component medical societies

Sixth District Councilor: James H. Skinner, Griffin (1980). Vice Councilor: Norman P. Gardner, Thomaston (1980).

Eighth District Councilor: Joe C. Stubbs, Valdosta (1980). Vice Councilor: Michael A. Glucksman, Brunswick (1980).

Medical Association of Atlanta Councilor: John T. Godwin, Atlanta (1980). Vice Councilor: James Norman Berry, Sandy Springs (1980).

Muscogee County Medical Society Councilor: Jack A. Raines, Columbus (1980). Vice Councilor: E. M. Molnar, Columbus (1980).

Bibb County Medical Society Councilor: Beverly B. Sanders, Macon (one-year term to complete unexpired term of Milton I. Johnson) (1978). Vice Councilor: Rodney M. Browne, Macon (one-year term to complete unexpired term of Beverly B. Sanders) (1978).

Annual Reports

Speaker Buchanan called for the Annual Reports of MAG Officers, Councilors and Committees and other reports to be introduced at this session which are listed below with the Reference Committee which these reports were referred appropriately indicated. (Editorial note: Each complete report, the action of the Reference Committee and the subsequent action taken by the House of Delegates on all reports referred to the Reference Committee will be found under the proceedings of the second session and the third session of the House of Delegates. See pages 390-481.)

OFFICERS

President—Annual Report (O/C1)—Reference Committee A
- Expanded Representation to House of Delegates —(O/C1A)—A

First Vice President (O/C4)—A

Second Vice President (O/C5)—A

Council
- Affiliate Membership of Mr. A. E. Nolan (O/C6A)—A
- Amendment to AMA Comprehensive Health Insurance Act (O/C6B)—C
- Clinical Laboratories (O/C6C)—D
- Resolution from Society of Anesthesiologists (O/C6D)—A
- Request for Proposal for PSRO Planning Contracts (O/C6B)—D
- Budget (O/C6F)—F
- Medicare Fee Schedule (O/C6G)—B
- Affiliate Memberships for Camden, Charleston Medical Societies (O/C6I)—A
- Affiliate Membership for DeKalb Medical Society (O/C6H)—A
- Accounting for CME (O/C6J)—D

Secretary (O/C7)—A
Treasurer (O/C8)—A
AMA Delegation (O/C12)—A
Speaker (O/C9)—A
MAG'S Quality Assurance Contracts (O/C6K)—B

COUNCILORS

First District (O/C13)—A
Second District (O/C14)—Not Referred
Third District (O/C15)—Not Referred
Sixth District (O/C16)—Not Referred
Seventh District (O/C17)—Not Referred
Eighth District (O/C18)—Not Referred
Ninth District (O/C19)—Not Referred
Tenth District (O/C20)—Not Referred
Bibb Medical Society (O/C21)—Not Referred
Cobb County Medical Society (O/C22)—Not Referred
DeKalb Medical Society (O/C23)—Not Referred
Floyd-Polk-Chattooga Medical Society (O/C24)—Not Referred
Georgia Medical Society (O/C26)—Not Referred
Muscogee Medical Society (O/C27)—Not Referred
Richmond County Medical Society (O/C28)—Not Referred
Medical Association of Atlanta (O/C25)—Not Referred

ASSOCIATION COMMITTEES

Scientific Assembly (C1)—D
Access to Health Care (C2)—Not Referred
Allied Health (C4)—Not Referred
Advisory Committee to Auxiliary to MAG (C5)—Not Referred
Cancer (C6)—Not Referred
Communications (C7)—A
Cost Accountability (C8)—D
Constitution and Bylaws (C9)—Constitution and Bylaws
Crawford W. Long Memorial (C11)—Not Referred
Disabled Doctors (C12)—F
Education (C13)—Not Referred
Emergency Medical Services (C14)—Not Referred
Health Planning (C18)—Not Referred
Joint Georgia Hospital Survey Project (C19)—A
Laboratory Quality (C20)—D
State Legislation (C21)—Not Referred
National Legislation (C22)—Not Referred
Liaison Committee on Human Resources (C23)—Not Referred
Liaison Committee to Georgia State Medical Association (C25)—A
Maternal and Infant Health (C26)
Recommendation 1, 2 and 3—C
Recommendation 4—D
Medicaid Negotiating Committee (C27)—B
Medical Aspects of Sports (C28)—D
Medical Practice (C31)—B
Medicine and Religion (C32)—Not Referred
Membership Insurance (C34)—A
Mental Health (C35)—Not Referred
Nursing (C36)—B
Occupational Health (C37)—Not Referred
Physician's Assistants
Majority Report (C40a)—B
Minority Report (C40b)—B
Chairman's Report (C40c)—B
Prison Health Care (C42)—Not Referred
Professional Liability Insurance (C44)—F
Public Health (C45)—D
Subcommittee on Rural Health (C47)—Not Referred
School Child Health (C48)—Not Referred
Third Party Relations (C50)—C
Transfusions and Transplantations (C52)—Not Referred
Ad Hoc Committee to Study Business Sessions for Interns, Residents, Students at MAG Annual Sessions (C53)—Not Referred
Ad Hoc Committee for Hospitalization Review (C54)—Not Referred
Ad Hoc to Study the Composite State Board of Medical Examiners (C57)—C

REPORTS OF DEPARTMENTS

Auxiliary to Medical Association of Georgia (B1)—A
Georgia Medical Care Foundation (B2)—A
Research and Development Division (D3)—Not Referred
Journal of the Medical Association of Georgia (B4)—D

The Speaker called attention to the reports which are shown as having no recommendations and thus have not been referred to any reference committee. He called upon the Delegates to request referral of any report they desire to see go to a Reference Committee. The Speaker then announced that all reports not referred to Reference Committee would be filed for information. They are as follows:

SECOND DISTRICT COUNCILOR (O/C14)

J. Dan Bateman, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Cloquitt Leonard P. LaConte Moultrie	19	16	18	14
Decatur-Seminole M. A. Ehrlich Bainbridge	13	8	11	9
Dougherty George M. Chastain Albany	84	73	86	68
Mitchell A. A. McNeill Jr. Camilla	3	3	3	3
Southwest Georgia David Wetherby Ft. Gaines	11	7	9	2
Thomas Area James L. Storey Thomasville	51	40	49	45
Tift William D. King Tifton	23	17	24	16
Worth R. T. Morgan Sylvester	5	4	5	2
	209	168	205	159

THIRD DISTRICT COUNCILOR (OC/15)

John H. Robinson III, M.D.

It has been my pleasure to serve another year as a member of Council from the 3rd District.

I will make the following observations: As we approach the future, it seems that we are facing higher and higher costs in the health care field. I believe that the key man in this field is the doctor. He is the one who can have an influence on these rising costs.

In my opinion, now is the time to stop, look and listen, and then let us join together and see if we cannot really make a dam large enough to stop this rising tide.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Flint Charles C. Greer III Cordele	15	13	15	7
Peach Belt James M. Alday Gainesville	43	38	42	36
Randolph-Stewart-Terrell John G. Bates Cuthbert	8	7	7	4
Sumter William R. Anderson Americus	25	20	21	18
	91	78	85	65

SIXTH DISTRICT COUNCILOR (O/C16)

James M. Skinner, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Clayton-Fayette Charles H. Hendry Riverdale	44	35	41	29
Coweta M. H. Cole Jr. Newman	24	19	24	21
Meriwether-Harris-Talbot William G. Chambless Hamilton	12	10	12	11
Spalding Robert J. Caswell Griffin	43	38	41	35
Troup Owen K. Tidwell LaGrange	40	33	43	33
Upson Benjamin S. Brown Thomaston	24	19	22	19
	187	154	183	148

SEVENTH DISTRICT COUNCILOR (O/C17)

Don Schmidt, M.D.

Growth in membership in the 7th District has been steady, with our total membership now standing at 144. The 7th District had two very successful District meetings in 1976-77. The Fall meeting was in Chattanooga, Tennessee, with the Spring meeting being held in Rome. Both were well attended and had excellent clinical programs. Each component society of the District is meeting regularly and carrying out their duties as prescribed by the Bylaws of the Medical Association of Georgia. Their condition is good. There is increased evidence of interest throughout the District in the problems of organized medicine.

This will be my final report as the 7th District Councilor, and it has been a privilege to serve. I feel sure that the 7th District Medical Society will continue to grow and all will contribute greatly to the progress of medicine and the Medical Association of Georgia.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Bartow William B. Dillard Cartersville	11	9	10	8
Carroll-Douglas-Haralson Jack Crews Carrollton	32	29	36	29
Gordon Bill Purcell Calhoun	9	9	10	9
Walker-Catoosa-Dade John W. Adams Jr. Ft. Oglethorpe	35	20	29	16

SEVENTH DISTRICT / Continued

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Whitfield-Murray				
William L. McDaniel Jr.				
Dalton	63	56	59	48
	150	123	144	110

EIGHTH DISTRICT COUNCILOR (O/C18)

Joe C. Stubbs, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Altamaha				
J. J. Hernandez				
Baxley	6	5	5	4
Ben Hill-Irwin				
George Mixon				
Ocilla	7	6	5	4
Coffee				
Jack G. Williams				
Douglas	16	14	18	12
Camden-Charlton				
Eduardo Oliveira				
St. Mary's	5	3	8	5
Glynn				
Ralph Chaney				
Brunswick	63	52	58	49
Ocmulgee				
Richard L. Smith				
Cochran	17	13	15	12
South Georgia				
Charles Hobby				
Valdosta	71	52	67	39
Telfair				
D. B. McRae				
McRae	4	4	4	4
Ware				
Edward B. Waxler				
Waycross	42	37	48	39
Wayne				
Ollie O. McGahee Jr.				
Jesup	8	5	8	5
	239	191	236	173

NINTH DISTRICT COUNCILOR (O/C19)

Harvey M. Newman, M.D.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Barrow				
J. C. Souther				
Winder	8	7	7	2
Blue Ridge				
E. J. Fernandez				
Ellijay	4	3	(disbanded)	
Chattahoochee				
Rupert H. Bramblett				
Cumming	27	24	26	24
Cherokee-Pickens				
F. E. Gonzalez				
Canton	20	14	18	7
Elbert				
Harold E. Campbell				
Elberton	8	4	7	4
Franklin-Hart				
Robert F. Sullivan				
Carnesville	7	6	8	8
Habersham				
Lamar H. Waters				
Clarkesville	11	8	12	7
Hall				
James M. Alday				
Gainesville	81	71	81	65
Jackson-Banks				
Sam A. Vickery				
Commerce	7	5	7	7
Stephens-Rabun				
Henry M. Hobby				
Toccoa	23	23	24	13
	196	165	190	137

TENTH DISTRICT COUNCILOR (O/C20)

Edwin W. Allen Jr., M.D.

Activity in the 10th District usual. List of eligible physicians not members of component societies not obtained at this time.

In the interest of brevity and streamlining procedures, no further report.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Baldwin				
Warren S. P. Henderson				
Milledgeville	52	28	50	22
Crawford W. Long				
William Holmes				
Athens	77	63	81	63
Jefferson				
A. F. Dumais				
Louisville	9	6	7	5
McDuffie				
Morgan N. Whaley				
Thomson	7	7	7	
Newton-Rockdale				
Robert L. Faulkner				
Covington	11	6	12	7
Oconee Valley				
William H. Rhodes Jr.				
Union Point	10	9	8	8
Walton				
R. M. Tankesley				
Monroe	7	5	6	
Wilkes				
Sophia B. Bamford				
Washington	5	5	5	5
	185	131	181	112

BIBB COUNTY MEDICAL SOCIETY COUNCILOR (O/C21)

Beverly B. Sanders Jr., M.D.

The Bibb County Medical Society has had an active year under the leadership of Dr. Jack Menendez, who in addition to his other activities found the time to testify before a House Subcommittee on Unnecessary Surgery.

The Bibb County Medical Society acquired 14 new members in 1976, had six drop-outs, and there are ten in the county who are not members of the Bibb County Medical Society.

MEMBERSHIP

County and Secretary	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Bibb				
Herbert S. Greenwald				
Macon	218	168	206	166

COBB COUNTY MEDICAL SOCIETY COUNCILOR (O/C22)

Charles R. Underwood, M.D.

The past year was an active and productive one for the Cobb County Medical Society under the presidency of Bob Coggins. A very successful effort to extend the activity and participation of the Society to the several hospitals in the county and to the now widely dispersed medical community was carried out. The transition from a single-county hospital with a centrally based medical community to a multi-hospital, county-wide hospital system with a widely dispersed medical community has been achieved smoothly and is now functioning more effectively.

The several activities of the Society continue to prosper. The Cobb County Symposium continues to grow and bring internationally known speakers to the Atlanta area for this yearly two-day Symposium. The members of the Society extended their yearly contribution of physical examinations to all high school students involved in athletics, to include the entire county.

We moved into new office space in the renovated area of the old Kennestone Hospital building and at the same time modernized both the physical facilities of the headquarters office as well as the mechanical functioning of the staff. Regular meetings of the Board of Trustees were held on a monthly basis during the year, with five general membership meetings being reasonably well attended. A newsletter published every other month has been established and continues to grow in quality. A Directory with vital information as well as black and white photographs has been published.

The tragic death of three of our young and prominent physicians in a single plane accident was memorialized by the Society by the establishment of a Scholarship Fund at Kennesaw Junior College in the name of these three physicians.

The Women's Auxiliary to the Cobb County Medical Society continues to be a very active and effective arm of the Society. Regular meetings and programs were held by the Auxiliary during the year. The ladies continue to operate a gift shop at Kennestone Hospital which during the past year contributed $65,000.00 to the hospital, all of which was donated either to purchase needed equipment at the institution or to subsidize the Medical Library.

MEMBERSHIP

County and Secretary	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Cobb				
Evans J. Nichols				
Marietta	204	169	216	165

DeKALB COUNTY MEDICAL SOCIETY COUNCILOR (O/C23)

Luther M. Vinton, M.D.

MEMBERSHIP

County and Secretary	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
DeKalb				
Charles W. McDowell Jr.				
Decatur	247	206	256	204

FLOYD-POLK-CHATTOOGA COUNTY MEDICAL SOCIETY COUNCILOR (O/C24)

John I. Dickinson, M.D.

MEMBERSHIP

County and Secretary	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Floyd-Polk-Chattooga				
Jack R. Edgens				
Rome	100	75	107	72

MEDICAL ASSOCIATION OF ATLANTA COUNCILOR (O/C25)

John T. Goodwin, M.D.
T. J. Anderson, M.D.
J. Harold Harrison, M.D.

MEMBERSHIP

County and Secretary	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Medical Association of Atlanta				
R. Carter Davis Jr.				
Atlanta	1102	934	1044	895

GEORGIA MEDICAL SOCIETY COUNCILOR (O/C26)

Joseph A. Mulherin, M.D.

MEMBERSHIP

County and Secretary	MAG	Members December 31, 1975 AMA Dues Paying	MAG	Members December 31, 1976 AMA Dues Paying
Georgia Medical Society				
J. Robert Logan				
Savannah	223	202	220	202

MUSCOGEE COUNTY MEDICAL SOCIETY COUNCILOR (O/C27)

J. A. Raines, M.D.

Membership in the Muscogee County Medical Society now stands at 205 members. In keeping with the recent emphasis on involving younger members of the medical profession, approximately one-fifth (42) are interns or residents. The Society created a dues structure appropriate for members still in the process of training. It is also our privilege to have seven service members currently stationed at Fort Benning. Currently, 11 members of the Society are over the age of 70, thereby excused from payment of dues but in all other respects are active members. By the time this report is printed, we anticipate an additional 13 new members of the Society. These numbers reflect the continuing growth of the Society encompassing individuals at every point along the way of their professional career. We have been able to identify only two physicians in our area who do not belong to the Society.

Numerical growth is only one reflection of vitality. Service to the Medical Society and the community at large is perhaps the more important measure. Dr. James Sullivan is First Vice President of the Medical Association of Georgia. His dynamic leadership has resulted in approximately 30 members of the local Society taking active committee assignments during 1976 for the Medical Association of Georgia. It is hazardous to single out individuals for special recognition when so many contribute of their time and energy. However, the importance of the health service areas is so awesome that a special commendation must be extended to Dr. John Watson who is the chairman of the Health Services Board in our area.

The importance of the Medical Association of Georgia has been re-emphasized by the selection of speakers for the Society meetings. Officers and committee chairmen from the Medical Association of Georgia have given generously of their time and knowledge to keep us informed of their activities and to solicit from the Society expressions of concern. Muscogee County was further honored by the presence of the Medical Association of Georgia Council for their meeting in February 1977. A significant number of the local Society joined with the Council for cocktails and dinner, providing an opportunity for the local members to meet those individuals whose deliberations have a continued and profound effect upon the practice of medicine in Georgia.

In summary, the Muscogee County Medical Association continues to grow both numerically and with regard to participation in the activities of the Medical Association of Georgia.

MEMBERSHIP

County and Secretary	MAG	Members December 31, 1975 AMA Dues Paying	MAG	Members December 31, 1976 AMA Dues Paying
Muscogee				
William C. Flanagan				
Columbus	176	135	176	127

RICHMOND COUNTY MEDICAL SOCIETY COUNCILOR (O/C28)

Ronald F. Galloway, M.D.

The Richmond County Medical Society has grown during the past year. Now, we have sufficient members to send 14 Delegates to the Medical Association of Georgia House of Delegates Sessions. Our meetings during the past year have been well attended, with 90 to 100 members present at most meetings. The programs have been varied and interesting. In general, it can be stated that the Richmond County Medical Society is functioning well in serving the physicians in the community as well as the community at large.

MEMBERSHIP

County and Secretary	MAG	Members December 31, 1975 AMA Dues Paying	MAG	Members December 31, 1976 AMA Dues Paying
Richmond				
Charles H. Wray				
Augusta	327	282	326	271

COMMITTEE ON ACCESS TO HEALTH CARE (C2)

M. C. Adair, M.D.

The Committee wishes to thank the Medical College of Georgia and Dr. Jon Calvert for providing the meeting place and the luncheon Saturday, January 15, 1977, in the new Sydenstricker Wing of the Eugene Talmadge Memorial Hospital.

The Committee is in thorough sympathy with the efforts of the Georgia Student Health Association to identify underserved communities and to work up a project in a few communities in the rural areas. One of the problems to be surmounted is lack of funding at this time for such an endeavor.

The Committee is in thorough accord with the idea of providing information to communities desiring new physicians, particularly in the primary care fields. The Medical Association will continue to work with communities and physicians in order to bring underserved communities and physicians together who are desirous of placement.

The Access to Health Care Committee further believes that a "Job Fair" or Health Manpower Fair might be set up in conjunction with a prepractice seminar to be held at Callaway Gardens in the Fall of 1977 with the help of Dr. Duttera. A mail-out to communities in Georgia, outlining the presentations which might be generated from communities at this Fair, will be made early this year. The October Fair itself, will be mainly for graduate physicians; however, since the material will already be available, it is hoped that this

same Fair can be held in Augusta for the benefit of medical students, perhaps in early December and again early in 1978 for the benefit of medical students at Emory University School of Medicine.

The Committee on Access to Health Care felt that the old format for the Rural Health Meeting, which traditionally has been held in August in Macon in conjunction with the Farm Bureau and the Extension Service along with the Medical Association, be changed to this new Job Fair. It is hoped that the Farm Bureau and the Extension Service will go along with the Medical Association on this new proposal.

COMMITTEE ON ALLIED HEALTH (C4)

J. Rhodes Haverty, M.D.

Although the committee did not conduct any business during the past year, it welcomes the suggestions of any MAG member about the training, credentialing, and practice of allied health professionals.

ADVISORY COMMITTEE TO THE AUXILIARY TO MAG (C5)

Milton F. Bryant Jr., M.D.

Activities of the 1976-77 Auxiliary began at the Annual Convention at Jekyll Island, Georgia with an hour-long orientation and a subsequent post-convention Executive Board meeting.

The summer Executive Board meeting was held in Atlanta, Georgia, July 19-20, 1976. In addition to two business meetings, eight professionally conducted educational seminars were given. These seminars have borne fruit in that the annual reports now being submitted by county auxiliaries show a great deal of activity across the state in the areas covered by these seminars. (See Annual Report of the President of the Auxiliary to MAG.)

The winter Executive Board meeting was held in Augusta, Georgia, January 18-19, 1977. This meeting consisted of two business meetings, reports of officers and chairmen and a report of the AMA Auxiliary Leadership Conference held in Chicago in October. This meeting was attended by the state president and eight county presidents-elect from Georgia. Mrs. Linus W. Hewit of Tampa, Florida, President of the Woman's Auxiliary to the Southern Medical Association was a guest at this meeting which was covered by both television and the press. A highlight of the board meeting was an idea exchange session between the county presidents.

The state president has been busy visiting the county auxiliaries, attending council meetings, keeping communications open between state and county and state and national levels. She has called upon the members of this committee for advice and has been pleased with their cooperation and help. The Auxiliary has grown in membership and in activities during the year and continues to give help and assistance to the Medical Association. Plans are now being made for the Annual Convention, April 21-23, 1977, at the Macon Hilton.

It will be of special interest to the members of MAG that the auxiliaries continue to give generous support to AMA-ERF and the William R. Dancy, M.D., Student Loan Fund. Two auxiliary members serve on the board of the Crawford W. Long Museum set up by the Medical Association and, through the auspices of a constitutent auxiliary, an original oil painting of Dr. Crawford W. Long is now on loan from the Atlanta Historical Society and has been hung in the museum in Jefferson, Georgia. Excellent progress has been made in the Allied Health Careers Clubs of Georgia this year. There are now five re-activated clubs, two new clubs and two additional new clubs in the process of organizing. Membership has grown accordingly.

It has been a pleasure to work with the members of our Auxiliary this year.

COMMITTEE ON CANCER (C6)

John Watson, M.D.

The committee has met this year to consider the problems associated with cancer in the State of Georgia. Recent reports of the Third National Survey revealed that estimates of the financial cost of cancer in Georgia exceed $200,000,000 per year.

Considerable attention is being paid at this time to means of preventing the development of cancer by modification of our life style. This specifically applies to environmental conditions as well as to nutritional considerations. Modifications of this type usually require the participation of government which controls more environmental standards, as well as some influence on nutritional products. It is emphasized again that appropriately timed educational programs can have more influence than any other program that could be instituted. It is felt that these programs must be instituted in elementary schools to become influential to the youth of today. If one waits until junior high or high school, too many deleterious habits have been acquired.

The overall care of the cancer patient in the state of Georgia appears to be consistently improving in quality, but there are still many areas that do not have the desired level of evaluation and therapy. As it has been well established that the first person who intervenes in the physical management of the cancer patient has the best chance of determining the eventual outcome, it is imperative that assistance be devised where more patients with potentially curable conditions will be seen by physicians experienced in the appropriate handling of the cancer patient.

Another need which has become more evident is the expertise necessary for the administration of chemotherapeutic drugs. Although there is some controversy as to the actual need for extensive prophylactic or near prophylactic use of these drugs, the appropriateness of application is even more important when they are utilized. As cancer is a somewhat unique and consistently more devastating disease than most afflictions, the management and the attendant cost of management of these patients also becomes somewhat unique.

The principles of team approach by several disciplines of medicine, and the assistance of other paramedical groups remains the most viable plan for assisting the patient with this dread disease. Our statistics reveal improvement in some areas and particularly acclaim the success of the Pap screening program which relates to early detection. Our overall progress, however, is still unacceptable in reducing the terrible toll that this disease inflicts upon the people of Georgia.

CRAWFORD W. LONG MEMORIAL COMMITTEE (C11)

E. L. Frederickson, M.D.

The first meeting of this committee was held the night of February 14, 1977, and all of the members were in attendance. The following information was passed on to the committee:

Collections utilizing the MAG dues statement have been excellent, with over 50% of the present dues-paying members contributing $10 for the benefit of the Crawford W. Long Museum. The committee was informed that the money in this account would be held in the general funds of MAG and would be available to the committee when they have approved projects for the Crawford W. Long Museum Memorial Foundation, and at that time the money would be transferred to that foundation.

There was some urgency in obtaining someone to do repair work on the coving and to point the stone work, caulk the windows, and paint the outside of the building. It was approved that this work should be done and that a contract should be obtained with a reputable company to perform this work. Mr. Tom Bryant, chairman of the Committee on the Building, will be informed of this, and when his estimate is received, this money will be transferred.

It was also suggested that painting of the inside of the building was needed very badly, and this project was also approved. The same procedure will be followed in this project.

A third project that had been suggested by the foundation was to obtain and place a sign on the southwest side of the exit from I-85 to Jefferson, comparable to the one that is on the northeast side of the freeway, advertising the museum. This project was also approved.

A general discussion followed regarding 1) the method that the city of Jefferson has utilized to budget the maintenance of the museum; 2) publicity regarding Crawford W. Long Day (Doctor's Day) and the program that is to be presented at the Jefferson schools on that day regarding further publicity of the museum and anesthesia in general; 3) what would be the policy in terms of accepting items for the museum, inasmuch as there is essentially no storage space available to the museum; 4) the need for books that directly relate to Crawford W. Long, as well as letters and other items that are still available but are becoming relatively rare at the present time. It was also suggested that photoduplicates or even Xerox copies should be utilized if necessary, but that perhaps we could get other items that could be rotated among other museums that are interested in these same items.

It was mentioned that two major acquisitions have been obtained through the will of a Mrs. Tutt, who was a grand niece of Dr. Long's, and these were his sterling silver baby cup and a set of portraits of his father and mother that were in very good shape. In addition to this, it was suggested that if anybody knew where there was a showcase somewhat similar to those that used to be in country stores, it would be a worthwhile addition so that we could display some of the items that the museum does have.

Other general discussion related to publicizing the museum through both MAG and AMA committee meetings, and the possibility of updating the exhibits in the museum as soon as we are sure that the building is weatherproofed and in good shape. Mrs. Oglesby from Danielsville raised the question in regard to the property and home of Dr. Long's father and mother. There was discussion in regard to this and fears were expressed that the house would degenerate if something was not done relatively soon. We all expressed interest in the project but could find no easy solution to how the home could be restored at its present location.

It was decided that the chairman would call a committee meeting whenever there was further need for a meeting later in the year.

EDUCATION COMMITTEE (C13)

Nicholas E. Davies, M.D.

This large committee continued to be quite active. The report will be divided into the areas covered by the committee's four subcommittees.

Accreditation. This subcommittee has been chaired by Dr. James Maughon and during the past year has conducted AMA accreditation surveys of nine organizations sponsoring continuing medical education programs. Those approved for accreditation are the Georgia Society of Ophthalmology, the Georgia Academy of Family Physicians' Educational Foundation, the Georgia Surgical Society, the Georgia Chapter of the American Academy of Pediatrics, Phoebe Putney Memorial Hospital in Albany, the Georgia Society of Anesthesiologists, and the Georgia Academy of Family Physicians. The total number of accredited organizations in Georgia is now 28.

Each accredited organization must be resurveyed from time to time in order to maintain its accreditation. Organizations reaccredited during the past year are the Medical Center in Columbus and the Georgia Psychiatric Association.

While most of the state's larger hospitals have been accredited, there are still some that have not been. This remains a concern of the Education Committee, which believes that all major hospitals should have an active educational program for physicians, one way of helping provide quality patient care.

The subcommittee continues to involve many physicians in its work and in fact depends upon the volunteered service of MAG members in order to conduct accreditation surveys. The entire Association owes a debt of gratitude to 22 of its members who took time out from their practices to conduct surveys during the past year.

Continuing Medical Education. This subcommittee has been chaired by Dr. Lamar McGinnis and is concerned especially with promoting education programs in community hospitals. During the year a number of hospitals communicated their interest in the development and accreditation of CME programs, and MAG's Director of Education, Dr. Stephen Daniel, visited and gave talks to the staff at hospitals in Dublin, Milledgeville, Statesboro, Carrollton, Americus, Warner Robins, Riverdale, Tifton and Moultrie.

The 1976 House of Delegates considered and rejected a recommendation by the Committee that CME be made a condition for membership in the MAG. The subcommittee continues to study the issue of mandatory CME, and members of the State Board of Medical

Examiners as well as some legislators have discussed the possibility of linking CME with a requirement to re-register periodically for one's license to practice medicine. Eighteen states presently have such legislation.

A group chaired by Dr. Austin Flint has been studying the use of patient care evaluation in identifying topics and types of continuing medical education activities. The members are currently involved in a demonstration project for which members of the committee visit hospitals of other committee members to discuss objectively audit findings. In March, Dr. Richard E. Thompson, formerly of the Medical Center in Columbus and currently on the staff of the Illinois Hospital Association, was brought to Georgia by this group to discuss assessment of patient care with members of the Education Committee and other interested persons.

The committee has assisted with several CME programs sponsored by the MAG. The principal one is the MAG Scientific Assembly held each November. The 1976 Assembly was bigger and better than ever and included excellent programs from 14 component specialty societies. A team of physicians from the AMA surveyed the meeting, and if its report is favorable, all of MAG's CME programs will have the potential of being accredited.

Another activity sponsored by the Committee and the Emory University Community Education Division was a one-day institute on "Decision-Making in Health Care," held in October, 1976. The institute took an interdisciplinary approach to the subject and was quite successful, attracting a good number of nurses, health educators, and some physicians from around the state. The institute was planned and arranged by Dr. Daniel of the MAG Staff and Mary Cobb Bugg of Emory.

The Committee also assumed responsibility for the Practice Management Workshops designed to help residents set up their medical practice. The response of the residents was enthusiastic at the Workshop held in Columbus in February, 1977.

The Small Hospital Library Project directed by Dr. Davies is concerned with helping small hospitals develop core libraries/information centers by establishing consortia with other hospitals, libraries, community colleges, etc. Funds are available from the National Library of Medicine for the development of these consortia. Considerable cooperation has been obtained from Miriam Libbey, Director of the Medical Library at Emory and also Director of the Southeastern Regional Medical Library Program (SERMLP), as well as Tom Basler, Director of Health Science Libraries at the Medical College of Georgia in Augusta. The MAG Library Project has encouraged the Atlanta Health Science Libraries Consortium to develop a display that was presented at the Scientific Session of the MAG as well as the Annual Meeting of the Georgia Hospital Association. The Education Committee has also encouraged the development of the Georgia Health Sciences Library Association. Dr. Davies gave a talk at the initial meeting of this group.

The subcommittee continues to promote the AMA's Physician's Recognition Award by publicizing the procedure for applying for the award as well as the names of MAG members receiving the award.

Medical Schools. This subcommittee has traditionally organized the Biennial Conference on Medical Education, which is designed to provide dialogue between the medical schools and practicing physicians. The 7th Biennial Conference was held in Macon in March, 1976, and included participants from MAG, Emory, Medical College of Georgia, Morehouse College, and Mercer University. Other than members of the Education Committee, attendance by MAG members was very poor, although the quality of the conference was good. Therefore, the committee has been debating the value of continuing the conferences. It was decided that the subcommittee should be kept intact but that no conference would be planned for 1978 unless there was evidence that such a meeting was indeed needed. The relationship between MAG and the medical schools is now good, and a biennial conference would not seem to have much to offer at this time.

Health Education. Considerable progress has been made by this active subcommittee. Drs. Harrel and Davies have headed up a group concerned with health education in the state school systems, which has met on three occasions with leaders in the health education field to discuss promotion of improved health curricula in the schools. As a result, the subcommittee has encouraged the State Board of Education to promote health education in the various school systems, and this is now being done to a limited extent. Dr. Daniel has been active with the Georgia PTA Committee on Health Education, which has produced a slide presentation on the need for comprehensive health education in the schools. It is hoped that the presentation will be given to parents, teachers, school board members, and community leaders throughout the state. The Auxiliary to the MAG has been very supportive and has in fact taken health education in the schools as one of its top priority projects.

Committee members have attended a number of meetings in Atlanta related to health education and patient education. Dr. Davies will speak in April to the Allied Health Careers Club of Georgia on health education of the public. Last September the MAG experimented with a health education program for its employees, arranged by Dr. Daniel with the help of speakers supplied by the Georgia Heart Association. The program was successful, and more are being considered.

Dr. Davies has resigned from the chairmanship of the Education Committee, and the Executive Committee has appointed Dr. Lamar McGinnis to be the new Chairman. Dr. Davies will remain as Co-chairman of the Subcommittee on Health Education. The new Chairman of the Subcommittee on Continuing Medical Education will be Dr. Carl Rosengart.

COMMITTEE ON EMERGENCY MEDICAL SERVICES (C14)

Carl Jelenko III, M.D.

The Committee on Emergency Medical Services met on Saturday, January 15, 1977. The major accomplishments of the committee during 1976 comprised advice and assistance to the Emergency Medical Service Unit of the Department of Human Resources in training and examining Emergency Medical Technician trainees.

The committee was involved, with MAG's Legislative Committee support, in working with three bills in the General Assembly. Senate Bill 19 (which would have made it unlawful to request ambulance service if

there was no reasonable need for such service) was supported by the Committee. House Bill 99 would have modified the ambulance law in such a way as to define the basic and advanced Emergency Medical Technician and Cardiac Technician. This Bill was vigorously supported. The Committee agreed to oppose House Bill 46 which would have required that the physician respond to a call from the Emergency Department within a fixed period of time or be liable for malpractice. The Bill was poorly drafted and would have had devastating effects on hospitals and physicians. (House Bill 46 was defeated in Committee; and House Bill 99 was adopted. At the time of this writing, the fate of Senate Bill 99 is unknown.)

The Committee will sponsor a brochure for mailing to the physicians of Georgia informing them of the availability and training of the more than 2,000 EMTs in Georgia. At the present time, there are 234 advanced EMTs and 36 Cardiac Technicians. The Committee continues to co-sponsor an Education sub-committee which also serves the Emergency Health Services Advisory Council of the Board of Human Resources.

The Committee learned that Dr. Charles Mosher will leave the Department of Human Resources at the end of March 1977 to enter practice in California. A resolution was proposed and adopted by the Committee commending Dr. Mosher for his significant contributions he has made in his two-year tenure as Director of the Emergency Health Services Unit and urging that a physician be sought for his replacement who would provide the same sort of interactions.

It is probable that the Committee will meet more frequently in 1977 and that the reduced need for meetings in 1976 was in large part due to the work and contribution of Dr. Mosher.

There were no resolutions or recommendations to the House of Delegates.

COMMITTEE ON HEALTH PLANNING (C18)

J. W. Chambers, M.D.

The Executive Committee on the MAG had charged this committee to maintain liaison with local health systems area boards and with the state HSA organization, to review and comment on local and state HSA plans, and to review legislative and regulatory activity with a view toward promoting the best interest of patients and physicians. The committeee members include physicians from each HSA Board. The HSA Executive Directors also participate in meetings. The committee has considered several issues of importance to physicians.

Lawsuit Testing Constitutionality of PL 93-641. The Medical Association of Georgia had received a communication from the Louisiana State Medical Association indicating that that organization had decided to test the constitutionality of the HSA law. The memorandum had further suggested that other state medical associations also pursue such a course. After discussing this question, the committee reached two conclusions:

1. The MAG should not become involved in a suit testing the constitutionality of this law, since there was already a suit being conducted in North Carolina with the participation of the American Medical Association. Such an action could have been undertaken by the MAG if no other state and the AMA had not done so. Action by the MAG would be redundant.

2. Although the HSA law has been reviewed by MAG legal counsel, it has not been looked at from the point of view of determining whether there are any conflicts in it with Georgia's Constitution and Statutes. It was suggested that the Executive Committee request MAG Legal Counsel to review this situation and advise of any possible conflicts. This has been done and no substantial conflicts were discovered.

SHCC—Representation. In discussing the membership of the SHCC (State Health Coordinating Council), the committee suggested to the MAG Executive Committee that the Governor be contacted and be advised of MAG's formation of the Committee on Health Planning. It was further suggested that the Executive Committee ask the Governor to consider naming the members of this Committee to the State Health Coordinating Council, expressing the Committee's interest in serving in this capacity as part of his selection of non-HSA recommended representatives. This suggestion was accepted by the Executive Committee.

Certificate of Need. The committee heard Ms. Patricia Leet of State Comprehensive Health Planning Office make a presentation on Certificate of Need Legislation for Georgia. Ms. Leet began by commenting on the fact that the Governor had not yet designated a State Health Planning Agency. This agency would be responsible at the state level for the Certificate of Need issuance. The Governor has stated that he will await HEW's official and final regulations before he makes a move on establishment of the State Health Planning Agency or the naming of the State Health Coordinating Council. Pursuant to the law, the latest that Georgia could put into effect Certificate of Need would be October of 1980. Ms. Leet indicated that if all the concerned parties could agree on a bill, then it would be possible to get it through the legislature this session. There would have to be a consensus of not only the HSAs and the State Planning Office, but also the major provider groups.

The Certificate of Need Law would cover all hospitals—psychiatric, tuberculosis and rehabilitative. It would cover skilled nursing facilities and immediate care facilities. All organized ambulatory health care facilities would be included. These facilities are defined as facilities not part of a hospital which are organized and operated to provide health services to outpatients. It would include: clinical health centers; family planning clinics; family health centers; neighborhood health centers; ambulatory surgical facilities (including centers for dental surgery); dental clinics; optometric clinics; community mental health centers; outpatient mental health facilities; prenatal and/or abortion clinics; drug abuse or alcoholism treatment centers; facilities for the provision of outpatient physical therapy services (including speech pathology service and rehabilitation facilities). Such term does not, however, include the offices of private physicians or dentists, whether for individual or group practice.

Any capital expenditure in excess of $150,000 or any change in beds, or any change in services, would be required to be submitted to the Health Systems Agency for the obtaining of a Certificate of Need.

In the committee's discussion several points were made concerning the problems that exist under any Certificate of Need law. It was pointed out that old, mediocre facilities could exist in an area and not be

appropriately utilized. A more efficient, newer facility would be unable to increase its capacity because of the old facility's existence. A number of questions were raised concerning the ability to judge the quality of facilities and services provided. It was pointed out that appropriateness review by the HSA should take care of some of these questions on a mediocre facility, inhibiting a nearby institution from increasing or expanding its services.

Committee members pointed out that time for a review should be adequate but not a prolonged period. The possibility of using an annual Letter of Intent to notify the HSA of a facility's expected application for expansion of services or facilities was brought up. Alternatives considered included submission of such a Letter of Intent approximately two or three months prior to the actual application. Another possibility was submission of Letter of Intent on a twice-a-year basis. It was pointed out by some of the members of the committee that by requiring such a Letter of Intent, it was quite possible that every facility in the area would submit a Letter, regardless of its real concern or real interest in filing an application. Since it might be possible that such an expansion would be requested, the facilities would go ahead and submit the Letter of Intent just in case.

The committee concluded that any Certificate of Need should be as flexible as possible, since there is so little experience with this type of activity in Georgia and since there are many questions about its effectiveness. The Committee agreed that MAG should be supportive and cooperative with other organizations such as the Hospital Association, Nursing Home Association, HSA's and with the state CHP in proposing a bill to the legislature on which all parties agreed. There still remained the question of appropriate time for the passage of such a bill or the appropriate effective date for the Certificate of Need Law. The MAG Council has maintained MAG's position of strongly opposing Certificate of Need legislation in principle. The Council has, however, directed MAG to participate in drafting a Certificate of Need bill which will be least objectionable and also to work toward implementation of this bill at the latest possible time warranted by the federal government.

The individual HSAs in Georgia are proceeding with their development at different rates. They all seem to be moving according to the schedules that have been set. Thus far, physician participation in all of the HSAs has been good. Of particular importance is continued physician participation in HSA committees and task forces.

COMMITTEE ON STATE LEGISLATION (C21)

James A. Kaufmann, M.D.

The 1977 Georgia Legislature ended at midnight Thursday, March 10, 1977. For various reasons, this was one of the most successful legislative sessions MAG has had. There were 67 legislative bills in which MAG took an active part. This activity came either by total support, total opposition or trying to amend and perfect the bill in regard to the health care delivery system.

Some of the most visible reasons for our success this year were: There are now two active MAG members serving in the House of Representatives both of whom are on the House Health & Ecology Committee. This is the committee where the majority of health related bills are assigned. Another reason is for the first time, physicians of Georgia and MAG members in a large number came to the Capitol and let their voices be heard. During the entire session, active MAG members could be seen roaming the halls of the Capitol talking to their Senators and Representatives and sharing their concern in the legislative process. The result and influence of personal appearance outweighs one hundred letters, phone calls and telegrams. More of us should do this in the years to come.

The two physicians in the Legislature, Wilbur Baugh, M.D., Post Office Box 926, Milledgeville, Ga. 31601, and J. Roy Rowland, M.D., 103 Woodbridge Road, Dublin, Ga. 31021, served the needs of all Georgians and portrayed the ideals of MAG throughout the entire 1977 Legislature Session. We, as Georgians and as fellow physicians and MAG members, owe them a great deal of gratitude.

Doctor-of-the-Day Program. MAG sponsors, during each legislative session, a Medical Aid Station which is staffed by volunteer physicians throughout the State of Georgia and is known in our ranks as the "Doctor-of-the-Day Program." This program serves two purposes. One being, physicians are available to treat the every day ills of our legislators and the second being this is a vital public relations link between physicians in Georgia and the Georgia Legislature. These volunteer physicians throughout the State gave one day of their time to come to Atlanta to serve the General Assembly this past year. They are to be commended for this effort but at the same time, I think each one of these physicians will state it was an educational experience for them.

The physicians who served as Doctor-of-the-Day this year were: James A. Kaufmann, Atlanta; Kevin Lane, Albany; Fleming L. Jolley, Atlanta; Wallace Lucus, Cochran; Roland Summers, Savannah; M. C. Adair, Rome; J. R. B. Hutchinson, Atlanta; Wells Riley, Jonesboro; Larry Freeman, Atlanta; Steven May, Kennesaw; James Marlow, Dalton; George Green, Sparta; Duane Blair, Decatur; Don Schmidt, Cedartown; Ben Looper, Canton; Barry Darugar, Eatonton; Henry Stegeman, Athens; Gerald Filardi, Decatur; Jack Johnston, Dahlonega.

Bill Strom, Decatur; E. Anthony Musarra, Marietta; Henry R. Richbourg, Nashville; Beverly Sanders, Macon; Stewart Brown, Royston; Rick Dubois, Atlanta; Charles Releford, Griffin; J. W. Chambers, LaGrange; Charles Gillespie, Albany; Jimmy Baugh, Milledgeville; Charles Durden, Fitzgerald; Bill Morton, Chamblee; Michael Oconnell, Waycross; Jack Menendez, Macon; James Traylor, Athens; Larry Freeman, Decatur; Curtis Hames, Claxton; Louie Griffin, Augusta; John Gamwell, Atlanta; Lamar Cousins, Marietta; Stewart R. Roberts, Atlanta; Hugh O. Hodges, Winder; James Dismuke, Adel.

Legislation of Interest to MAG. Of the 67 bills introduced this year, MAG took special interest in the following:

H.B. 46 Hospitals-Emergency Room Physicians

Failed in the House Committee; MAG strongly opposed. This bill would have required every hospital to designate a primary and a secondary call practitioner

for emergency room care. The primary call practitioner would have twenty minutes to respond to the emergency call and the secondary practitioner would have forty-five minutes to respond to the emergency room call and both would be liable for any medical malpractice or negligence which might have occurred after their respective times if they had not arrived.

H.B. 57 Generic Drug Substitution

Passed House and Senate; MAG did not oppose. This bill requires, effective January 1, 1978, every prescription form be changed to include two lines on which the physician may sign. The top line indicates "generic substitution permitted" and the second line indictates "dispense as written."

H.B. 61 State-Wide Catastrophic Health Insurance

Pending before the House Insurance Committee; MAG supports. This bill would require health insurers to offer catastrophic coverage to the enrollees who could accept or reject the coverage. Patients would become covered under these plans when their cost exceeded $5,000.00. All reasonable and customary medical or health care charges for treatment furnished or prescribed by a physician could be covered. Co-insurance would be prohibited. We anticipate a hearing by the House Insurance Committee on this bill some time during the summer. If anyone knows of a specific catastrophic case, please contact MAG Headquarters so this information can be compiled and offered as testimony during the hearing this summer.

H.B. 212 Board of Medical Examiners Reports by Hospitals

Passed House and Senate; MAG supported. This bill requires all hospitals to report to the Board of Medical Examiners those physicians whose hospital privileges have been revoked. This does not apply to suspension of privileges due to record keeping and only applies to those privileges suspended after all appeals have been sought.

H.B. 234 Health Maintenance Organizations

Passed the House Insurance Committee, defeated by the House, reconsidered and tabled. This bill would permit Georgia to conform with the federal laws and enable HMOs to obtain initial start-up money from the federal government. MAG's basic philosophy is in opposition to Health Maintenance Organizations.

H.B. 244 Maternity Insurance

Passed both House and Senate. This would require those insurance companies who write a maternity insurance package to include in this package complications of pregnancy. MAG supported H.B. 244.

H.B. 251 Board of Medical Examiners—License to Practice Medicine

Passed House and Senate, now law. MAG vigorously supported. This new law states a Judge cannot suspend the Medical Board's revocation of a doctor's license without first making a positive finding that by allowing the doctor to continue practicing, it will not endanger the public's health.

H.B. 252 Board of Medical Examiners—Immunity from Liability

Passed House and Senate, now law. MAG vigorously supported. This states those persons who provide information to the Medical Board are given immunity from being sued by the doctor whom they give information about as long as their testimony and/or information to the Board is given in good faith.

H.B. 451 Regarding Board of Medical Examiners
(Passed House and Senate)

This bill authorizes Composite State Board of Medical Examiners to appoint an Executive Director, Medical Coordinator and members of peer review committees. Provides that proof of internship in an approved hospital shall not be required to receive a license to practice medicine for doctors who graduated on or before January 1, 1967. Deletes the provision that requires the Board to include on the license the educational degree of the licensee. Deletes the requirement that a person licensed to practice medicine display on his stationery and business cards the educational degree which he has received. Deletes a special authorization for an alien with an institutional license to stand the examination for licensure as a doctor of medicine (U.S. Supreme Court mandated this change).

Allows the Board to set the fee for licenses issued by the Board. Provides that any person who has resided in the State for one year and who has graduated from an accredited school may receive an institutional license to practice medicine in a state institution or medical college in Georgia. Provides that the renewal of such institutional license is at the discretion of the Board. Provides that the residency requirement for an institutional license may be waived for aliens who teach in medical schools. Provides that a person with an institutional license cannot engage in the private practice of medicine. Provides that provisional licenses shall be renewed annually and clarifies the requirement that a provisional licensee must practice in a specific geographic location in the State. MAG and the Board of Medical Examiners supported H.B. 451.

H.B. 471 Podiatrist Insurance Coverage

Pending before the House Insurance Committee. MAG opposed. This bill would require any individual and group policies of accident and health insurance wherever such policy provides for reimbursement for any services which are within the lawful scope of practice of a podiatrist *shall* mandatorily reimburse podiatrist for said services.

H.B. 489 Psychology Practice Act

Pending before the House Insurance Committee. MAG Legislative Committee in conjunction with the Georgia Psychiatric Association reviewed H.B. 489 on numerous occasions and although had no specific comments during this legislative session, continued to keep an eye on the legislation to insure that this new draft of a Psychology Practice Act will not be detrimental to the patients and at the same time will not permit psychologists to do more than they are trained to do.

H.B. 502 Medicaid Reorganization

Passed House and Senate, now law. This officially, by Georgia Statute, takes the Department of Medical Assistance out from under the Department of Human Resources.

H.B. 632 Laymen—Board of Medical Examiners

Pending before the House Health and Ecology Committee; MAG neither vigorously opposes nor supports but can see no benefit from laymen serving on the

Composite State Board of Medical Examiners. This bill would expand the current Board from twelve to fifteen and mandate that three members of said Board be non-physicians.

H.B. 692 Blood Test—Premarital Examinations

Passed House and Senate; MAG supported. Currently, the forms for premarital examinations, when signed by a physician, indicate a complete physical has been performed. In most cases, only the standard serologic test have been performed. This new law changed the forms so the physician could indicate whether a complete physical had been performed or just a serologic test performed. This would remove any doubt or speculation as to whether a physical examination had been performed or not.

H.B. 769 Cancer Advisory Committee

Passed House and Senate; MAG supported. This law creates a Cancer Advisory Committee to the Department of Human Resources and the State to establish programs of prevention, control, etc., and to advise the State as to the dangers of cancer and as to the needs of monies by State appropriation in this area. One main purpose of H.B. 769 is to prevent in the future monies which should go to the cancer program being sidetracked to other departments under DHR.

H.B. 920 Certificate of Need

Pending before the House Insurance Committee. MAG opposes concept of Certificate of Need legislation. This bill, introduced late in the session, is mandated by Federal law for Georgia to have a Certificate of Need law in operation by January 1, 1980. For this reason, there is no rush for H.B. 920 to be passed. MAG policy on this bill is to insure that H.B. 920 does not go one inch further than mandated by Federal law.

S.B. 18 Adoption Law

Passed House and Senate, already signed by the Governor; MAG supported. This new law completely rewrites Georgia's old and antiquated adoption laws. MAG committees and others worked on this bill for the past three years for adopting a version suitable for the Georgia Legislature.

S.B. 20 Optometry

Pending before the Senate Human Resources Committee; MAG vigorously opposes. Under this proposal, Optometrists would be able to use diagnostic drugs without having received adequate education and training as to the side effects and uses of said drugs.

S.B. 85 Malpractice Testimony—Local Level

Passed the Senate, pending before the House Judiciary Committee; MAG supports. The Senate version of this bill states testimony pertinent to a professional liability case can only be given by persons who are familiar with that mode of practice within the State of Georgia. The results of the passage of S.B. 85 would seriously curtail those professional witnesses for hire.

S.B. 99 Emergency Medical Technician

Passed House and Senate; MAG supported. Under this proposal, all EMTs will be certified and supervised by the Composite State Board of Medical Examiners. Additional funds have been provided to the Board to certify EMTs.

S.B. 253 Psychology Insurance Coverage

Passed Senate Human Resources Committee; recommitted to the Senate Banking, Finance and Insurance Committee; MAG opposes. This bill would mandate reimbursement for services within the scope of practice of applied psychologist when said policy provides for reimbursement for any service which is within the lawful scope of practice of applied psychology. Current law states when an insurance policy has basic coverage for what a psychologist may do and said patient is referred to a psychologist by a physician, then and only then, may the psychologist be reimbursed by the insurance company.

S.B. 280 Mentally Retarded Persons—Emergency Treatment

Passed House and Senate; MAG supported. This bill provides that in cases of grave emergency where emergency treatment is determined by two licensed physicians as to be crucial to the danger and the health of the patient, then in that event, essential surgery or other intervention may be administered without the consent of a person, spouse, next of kin, attorney, guardian, or any other person.

S.B. 297 Driver's License Advisory Board

Passed House and Senate; MAG supported. Before the passage of S.B. 297, wording of the law stated that physicians shall report to the Department of Public Safety those persons who in the physician's estimation, could not drive an automobile safely. MAG requested the word *shall* be changed to *may* which was the effect of S.B. 297.

S.B. 313 Psychiatric Insurance Coverage

Currently pending before the Senate Banking, Finance and Insurance Committee. S.B. 313 states that under definition of physician or surgeon under all insurance policies shall not exclude any persons licensed under Code Chapter 84-9, Georgia Medical Practice Act. Specifically, this would include psychiatrist and any other M.D. group in Georgia. There should be a hearing on S.B. 313 in late summer.

S.B. 369 Hypnotism

Currently pending before the Senate Judiciary Committee; MAG supported. This bill was introduced late in the session and the hearing on the Hypnotism issue will come up during the summer months.

Resolutions. Several Resolutions were introduced into the Georgia Legislature creating specific study committees over the interim between 1977 and 1978 Legislature. Those to which MAG will attempt to give input are:

S.R. 92 Mental Disability Laws Study Committee

S.R. 94 Cost of Care Study Committee for Mentally Ill

S.R. 110 Mental Health Retardation Services Study Committee

S.R. 112 Optometry Study Committee

S.R. 136 Senate Product Liability Study Committee

S.R. 158 Certificate of Need Study Committee

As one can tell by the above mentioned bills, your committee has been extremely active during this past three months in the 1977 Georgia Legislature. We anticipate being more active this summer than we have during the past several years due to the number of

bills that are carried over to the next legislative session. We urge your support and help in communicating your wishes and our wishes to our State Senators and State Representatives over the summer, into the fall and during the 1978 Georgia Legislature. We will be in communication with you regarding these issues periodically during the summer and fall months. With active participation of all members, we can accomplish any goal that is in the best interest of the people of Georgia.

As Chairman of the Legislative Committee, I would like to commend the work of the MAG staff on legislative matters, specifically, but not limited to, Mr. Rusty Kidd, Mr. Charles Templeton, Mr. Adam Jablonowski and Mr. Jim Moffett.

COMMITTEE ON NATIONAL LEGISLATION (C22)

Harrison L. Rogers Jr., M.D.

The 95th Congress is now in session and at its helm is none other than our own James Earl Carter, President of our United States of America. Our congressional delegation changed somewhat during this last election. Neither of our U.S. Senators, Sam Nunn nor Herman Talmadge, were up for re-election. Of our ten congressional seats, we have three new U.S. House members. From Georgia's Eighth Congressional District, our new congressman is Billy Lee Evans from Macon. From our Ninth Congressional District, our new congressman is Ed Jenkins from Jasper and from our Tenth Congressional District, our new congressman is Doug Bernard from Augusta. By the time this report is published, we will have one additional new congressman from the metro Atlanta area, Georgia's Fifth Congressional District. This race will be held on March 15, 1977. As you can see for one reason or another of our ten congressional seats, this last election gave us a 40% change-over.

We are very fortunate in that in all of our congressional campaigns, physicians played a very active part in the election or the re-election of our congressmen. This participation and involvement on your part will pay dividends when the physicians of Georgia contact our congressional delegation and express to them viewpoints regarding specific health legislation in the Congress and the ultimate vote that our congressmen cast on these issues. Each member of our congressional delegation has already contacted MAG and expressed their appreciation and concern that MAG and physicians in Georgia took regarding their congressional races. As you can see, MAG is well known to our congressmen and in the future will be better known.

Your National Legislative Committee took a delegation of Georgia doctors to Washington in mid-January for a luncheon with our Congressmen and Senators. We were fortunate to have both our U.S. Senators and nine of our U.S. Congressmen to participate in our Annual Congressional Luncheon. The MAG members who participated in this luncheon and were assigned to individual congressmen were:

Georgia's First District: Dr. John L. Hendley, Millen, liaison to Congressman Ronald "Bo" Ginn. Georgia's Second District: Dr. Charles B. Hollis Jr., Albany, liaison to Congressman Dawson Mathis. Georgia's Third District: Dr. Jack A. Raines, Columbus, liaison to Congressman Jack Brinkley. Georgia's Fourth District: Dr. O. Wyche Stubbs Jr., Chamblee, liaison to Congressmen Elliott H. Levitas. Georgia's Fifth District, Dr. Fleming L. Jolley, Atlanta, liaison to Congressman Andrew Young who did not attend the luncheon. Georgia's Sixth District Congressman, John J. (Jack) Flynt Jr.; his physician, Dr. William King was unable to attend.

Seventh District: Dr. John Dickinson, Rome, liaison to Congressman Larry McDonald. Eighth District: Dr. Jack F. Menendez, Macon, liaison to Congressman Billy Lee Evans. Ninth District: Dr. John W. Garland III, Gainesville, liaison to Congressman Ed Jenkins. Tenth District: Dr. John M. (Pepper) Martin. Augusta, liaison to Congressman Doug Bernard.

Liaison to both Senator Herman Talmadge and Senator Sam Nunn were Dr. James A. Kaufmann, Atlanta, and Dr. Harrison L. Rogers Jr., Atlanta. Staff attending this luncheon were Jim Moffett, Executive Director of MAG and Rusty Kidd, Director of Legislative Activities for MAG.

In the opinion of the National Legislative Committee and those physicians who went to Washington, this luncheon was an overwhelming success. There was good rapport among the physicians and our congressmen on health issues that were discussed during lunch.

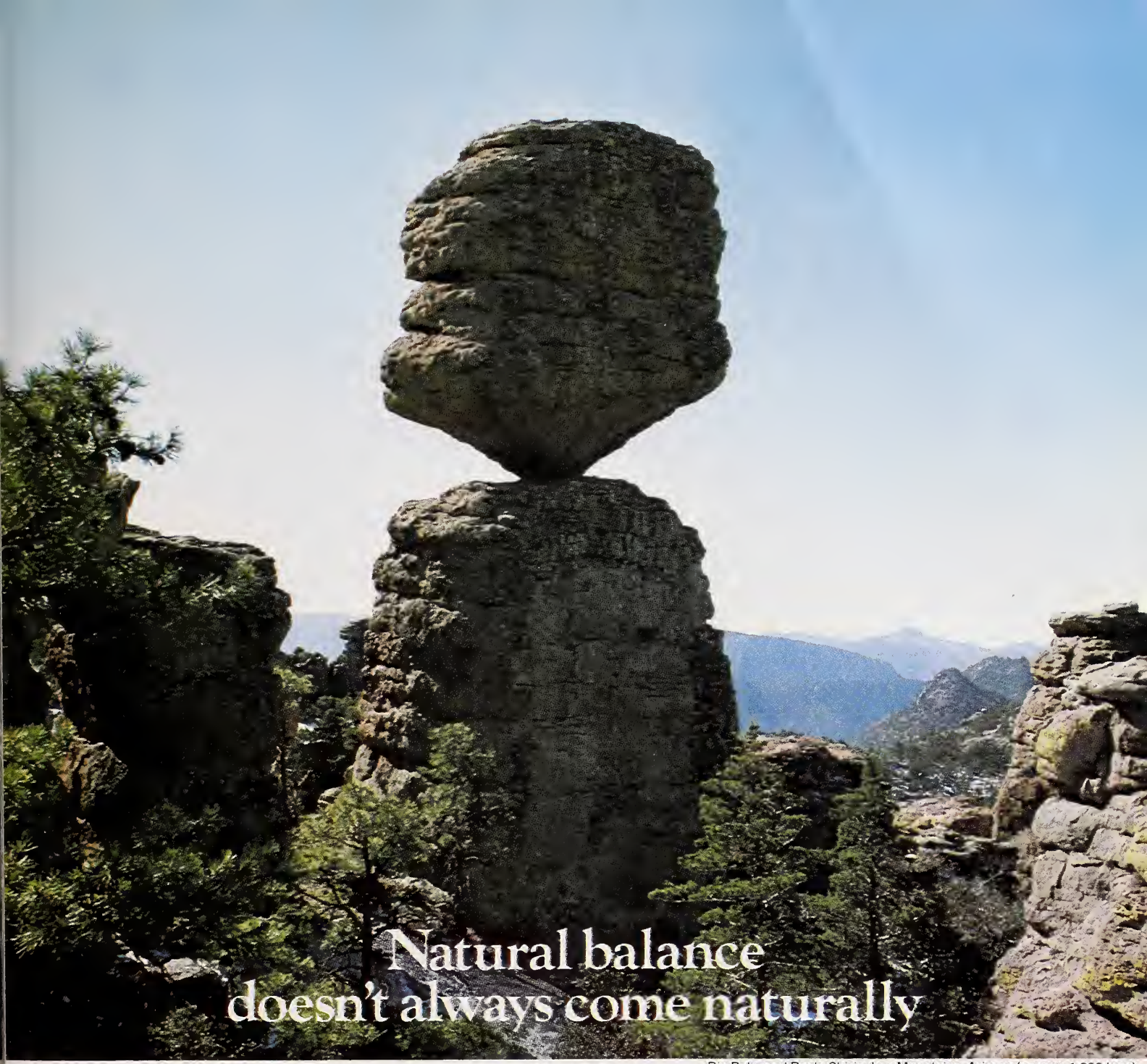
During the 94th Congress, 24,283 bills were introduced, 588 were inacted, 39 bills were vetoed, 7 of those vetoes were over-ridden. The Senate was in session 320 days, the House was in session 311 and it took 82,890 pages of the *Congressional Record* to record the business of the 94th Congress. The AMA and its affiliate organizations such as MAG, offered its views to the committees of the 94th Congress on 86 separate occasions.

During the 94th Congress, many issues which were related to medicine were introduced. These ranged from National Health Insurance, PSRO's, drugs, administrative rule making by bureaucratic agencies, Medicare, Medicaid, clinical laboratories, clean air acts, Medicaid fraud, Physician Extenders Reimbursements, Health Professional Educational Assistants and numerous others. Several of these issues have now become law and others will be re-introduced during the 95th Congress.

A brief recapitulation of legislation introduced last year and legislation to be introduced during the 95th Congress of concern to MAG and every physician in Georgia are listed below:

National Health Insurance. Neither the AMA version of NHI nor the Kennedy version passed the 94th Congress. Under the new presidential administration, we can look forward to a National Health Insurance Bill being introduced early in 1978. The Carter Administration has publicly stated there will be no administrative National Health Insurance Bill this year, but you can look forward to one next year. As NHI Bills are introduced, your committee will keep you abreast of each and every bill so you will be informed and asked to contact your Congressman regarding each bill.

PSROs. During the last congress, AMA bills were introduced in both the House and the Senate to amend the PSRO law. While no specific action was taken on these bills in their entirety, portions of the proposals were incorporated in P.L. 94-182, the Social Security



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE®

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes (see Warnings).

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

Amendments, which were enacted December 31, 1975. There will be additional hearings on similar PSRO legislation and implementation of the PSRO law during the 95th Congress.

Administrative Procedures and Rule Making. This original bill, introduced by Georgia's Fourth District Congressman, Elliott Levitas, received a great deal of attention, enthusiasm and support in the 94th Congress. Hearings were held in both houses and in both, no measure was passed. The AMA offered testimony in support of the AMA bill which differed somewhat from Congressman Levitas' bill but had the congressman's support. This legislation which will revise the rule making powers of the bureaucratic agencies is expected to be considered early in the 95th Congress.

Medicare-Medicaid. During 1976 our own Senator Herman Talmadge introduced legislation dealing with fraud and abuse alleged in the Medicaid program. Hearings relating to this issue were held in both the House and the Senate. The Senator's bill called for a comprehensive reform of Medicare-Medicaid procedures, and was intended among other things, to eliminate inefficiency and reduce fraud in these programs. The bill included the provision for an inspector general in the Department of Health, Education and Welfare to investigate health administrative programs. This bill also would set limits on amounts and circumstances under which Medicare reimbursements would be made and special limitations on reimbursements for services by hospital associated physicians.

Late in the session, a separate bill was introduced to control fraud and abuse in the Medicare and Medicaid programs. This bill provided for the establishment of a central office for fraud and abuse control for HEW health programs. Neither the Senate bill nor the House bill passed during the 94th Congress. Similar bills have already been introduced this year and will probably pass in some form during this congress. Congress did establish an office of Inspector General in HEW to investigate fraud and inefficiency in all HEW programs.

Senator Talmadge has issued a call for cooperative effort. Senator Talmadge stated, "There is friction between governmental payors and physicians and this friction is here to stay. The task for both congress and physicians, is to develop constructive solutions by dealing candidly, cooperatively and open-mindedly with each of them." Senator Talmadge predicts that his amendments to curb Medicare-Medicaid fraud and abuse will pass early in this session of congress.

Clinical Laboratories. In both Houses, bills were introduced to extend regulatory controls on clinical laboratories. These controls would require either federal licensure of their operations or comparable state licensure. These requirements would apply to *all* laboratories, including those located in physician's offices with only *limited* exemptions. A bill was passed by the Senate and final action on the legislation was delayed when the House failed to receive a two-thirds vote in favor of suspension of the rules which would have permitted its consideration prior to adjournment.

This legislation will be re-introduced in the 95th Congress. You will be kept informed of its status and details of the exemptions for physicians' laboratories.

Physician Extenders. Under this bill, the physician extender is defined to include a physician's assistant, medex, nurse practitioner, and any other practitioner who performs under the supervision of a physician. He must be authorized to perform under state law the services rendered and must meet such training, education, and experience requirements as the Secretary of HEW may require.

This legislation would change present law in two ways: First, the services of the physician extender would be eligible for reimbursement by Medicare-Medicaid. They cannot now be paid for services they perform except to the extent that they are incidental to the services of the physician. However, such services would have to be rendered by a physician extender in a rural health clinic and only the rural health clinic would bill for such services. The bill does require a physician extender to be under the supervision of a physician. Hearings have already begun on this issue.

It has been my pleasure for the past few years to serve MAG in the capacity as Chairman of the MAG Committee on National Legislation. Due to other assignments which have been made, I requested MAG not to re-appoint me as Chairman of this very important committee, but still consider me as a member. I offer to you, individually, and to the Medical Association of Georgia my full cooperation and assistance with this committee. During the years I have served as Chairman, my association with our national legislators has been rewarding and I would commend active communication by all MAG members with their representatives. Each of you is aware of the importance of health legislation already passed, such as Medicare, Medicaid, PSRO and HSA and how each has affected your own practice. Pending legislation such as Manpower changes, laboratory controls, Medicare and Medicaid changes as well as national health insurance all foretell even greater changes in the delivery of medical care.

It is important for organized medicine at all levels (county, state, national) to evaluate proposed legislation and to make this evaluation available to you. While your committee will remain active, it is absolutely essential that each member of MAG be aware of suggested legislation together with medicine's evaluation of it and communicate these views to your representatives. A close relationship with them before the need for help arises will pay great dividends.

I would like to express my personal appreciation to Mr. Rusty Kidd for his valuable assistance and guidance, to Dr. James Kaufmann and to each of the committee members who have all worked so hard on your behalf. MAG owes each of these men a great debt.

LIAISON COMMITTEE ON HUMAN RESOURCES (C23)

George F. Green, M.D.

The committee is appreciative of the allowance of $4,000.00 to be spent for actual expenses, even though it was hardly used. We request that the same be allocated for this year.

The committee members have, for various reasons, been unable to attend the board meetings as faithfully this year as they did in prior years. This is to be regretted because the socialistic takeover of medicine becomes more and more evident. It should be mentioned

that the Human Resources Board meets every third Wednesday, the meetings are open and the physicians of Georgia should make an attempt to attend some of these meetings.

At present, it appears that even the obstetrical deliveries are to be removed from the community hospitals, unless the Board can be made to use some logic in their considerations. They are following the same course that removed the "high risk" deliveries from community hospitals to regional centers which, in fact, has resulted in *no* prenatal care with the obstetrics patient appearing in the local hospital emergency room in the last stages of labor so that they are of necessity delivered and are "high risk" in all of its definitions. Each of you is asked to assist as they chip away at medicine.

Because of rulings of the Attorney General, some of our valuable board members have had to resign and have been replaced by what appears to be conscientious physicians and laymen. Many of the power structure have gone to Washington and the attitudes of their successors will have to be determined.

It is the hope of this committee that some rational approach can be made to provide for those in true need and to allow medicine to be practiced as best as possible by the practicing physicians of Georgia without the ever entwining tentacles of government controls.

COMMITTEE ON MEDICINE AND RELIGION (C32)

John W. Walker, M.D.

In our capacity as physicians, we can impart to our patients and others the validity of a deep religious experience. Our training as physicians may have negated this.

The revered Sir William Osler stated that physicians can have an abundance of both "the water of science and the oil of faith." He advised that we not attempt to mix them.

The need for a religious faith has always been great and that need has never been greater than today.

May we as physicians seek that faith and may it be passed on to our patients who trust their health and lives to us.

COMMITTEE ON MENTAL HEALTH (C35)

William S. Davis, M.D.

The year 1976 was one in which your committee saw the passage of S.B. 208, the so-called Mental Health Bill. This piece of legislation was of great interest to the Mental Health Committee who worked diligently to influence its passage.

We welcomed Dr. Allerton as the new Director of the Division of Mental Health, and, your Chairman, as a member of the DHR Board Liaison Committee is looking forward to working with him.

We are happy to report that the new forms which were worked out with Blue Cross/Blue Shield have been well accepted. With one or two exceptions which have been resolved, there have been no questions regarding the information requested.

It was with pleasure that the committee learned of the Reference Committee recommendation to include a psychiatrist on the Disabled Doctor's Committee.

OCCUPATIONAL HEALTH (C37)

Tom Howell, M.D.

The Occupational Health Committee had its annual meeting in March, 1976. There were two guest speakers present. Mr. John Andy Smith, Legal Consultant for the Workmen's Compensation Board reviewed the status of Workmen's Compensation changes. Mr. Robert A. Bell, Equal Opportunity Co-ordinator for the Georgia Power Company described the new Federal Guidelines requiring hiring the handicapped. Further discussion included evaluation of E.E.O.C.'s program, decisions and its affect on industry.

The committee discussed the possibility of reviewing various changes in industrial health, but felt such expenditure was not appropriate, since the majority of physicians who are interested in this type of work are members of other industrial health organizations.

The entire Workmen's Compensation Act of Georgia was revised during 1976 and introduced into State Legislature in January, 1977. This includes a subsequent injury fund. No comment is made at this time on chances, since there is some question whether the Act will pass.

The Toxic Substance Act became effective on January 1, 1977. This program is not under the administration of the Occupational Safety and Health Act, but under the control of the Environmental Protection Agency.

Chairman of the Occupational Health Committee is to meet with representatives of the International Association of Industrial Accident Boards and Commissions on February 4, 1977. The purpose of the meeting is to establish guidelines for a Federal Workmen's Compensation Act. The Medical Association will be advised of significant recommendations.

COMMITTEE ON PRISON HEALTH CARE (C42)

J. Rhodes Haverty, M.D.

This committee's functions during this, its first year, have been devoted exclusively to providing guidance and input to MAG's Project to Improve Health Care in Jails (a subcontract from the AMA).

The committee has closely reviewed AMA's proposed standards for health care programs in jails; its comments have influenced a significant revision of over 50% of those proposed standards.

The committee also has reviewed summary data and project recommendations for improving health care in Georgia's five participating pilot jails. The committee sees training programs of various types for jail health personnel and other jail personnel being provided in 1977 and 1978 as a result of these recommendations.

SUBCOMMITTEE ON RURAL HEALTH (C47)

Irving D. Hellenga, M.D.

The activity of the Subcommittee on Rural Health centered around the Rural Health Conference, held at the Macon Hilton on August 25 and 26, 1976. This conference has always been a joint promotion of the Rural Health Subcommittee, the Georgia Farm Bureau,

and the Cooperative Extension Service.

This year's Rural Health Conference dealt with two topics. The first was "Current Controversies in Nutrition." Discussion of obesity, fat diets, supplemental vitamins, fiber in the diet, health foods, and the relation of cholesterol and other fats to heart disease was the order of the day.

The second topic dealt with the distribution of physicians in Georgia and the provision for training adequate primary physicians for both rural and urban areas of Georgia. It was recognized that the Sears Foundation Program was not sufficiently successful to continue. National Health Service Corps will continue to provide subsidization for young physicians willing to try practice in underserved areas.

The State Medical Education Board has sought legislation to increase the scholarship amount from $10,000 to $15,000 per annum, and to increase the size of the community served from 10,000 to 15,000 people. Family Practice Programs operating in this state, or about to commence operation, will be more adequately meeting the need for provision of primary care. But some counties, with low population density, decreasing retail sales, decreasing population, but an increasing per capita income because of accumulation of property, probably will not be able to attract physicians. The current primary physicians are eager for post-graduate study, and have received material assistance from the postgraduate programs of the Medical College of Georgia and of Emory.

The Subcommittee on Rural Health will plan to promote the future activity of the Committee on Access to Health Care, with regard to the plans for a "Doctors Job Fair" to be held at Callaway Gardens this year. The Subcommittee also will recognize and attempt to capitalize on the enthusiasm of the present crop of medical students in promotion of its programs.

COMMITTEE ON SCHOOL CHILD HEALTH (C48)

James B. Dunaway, M.D.

The committee did not meet or conduct any business during the past year.

COMMITTEE ON TRANSFUSIONS AND TRANSPLANTATIONS (C52)

Frank Matthews, M.D.

There have been no new matters to come to the attention of the Transfusion and Transplantation Committee. We are still waiting for information from the American Blood Commission as to guidelines that may be used for forming a regional blood center. We are fearful that the ABC may drag its feet so long that the federal government will intervene. In the meantime, however, we can only wait.

AD HOC COMMITTEE TO STUDY BUSINESS SESSIONS FOR INTERNS/ RESIDENTS/STUDENTS AT MAG ANNUAL SESSIONS (C53)

James H. Sullivan, M.D.

Although this committee was originally charged to consider the possibility of establishing business sessions for interns/residents/students at the MAG Annual Session, additional items had been referred to it by the MAG Executive Committee. The Committee's recommendations have been referred to and acted upon by the Executive Committee and Council. This report to the House is for its information. Background information and reports which covered in great detail various subjects which had been referred to the Committee were distributed. The Chairman asked the Committee members to review this information and to feel free to make any comments, changes or additions which they might think necessary.

In discussing the establishment of a business session for house staff, it was pointed out that there might be considerable difficulty in getting these individuals away from their hospitals to attend the MAG meeting. Additionally, it was suggested that since residents are physicians—M.D.—they could certainly participate fully in MAG through their County Medical Societies. It was emphasized that the County Medical Society level was the best opportunity for the resident to get indoctrinated in the affairs of organized medicine. The Committee concluded that MAG should encourage County Medical Societies to obtain active house staff participation in the Societies' committees and meetings.

It could be quite possible that if the residents were interested enough, they could stand for elections as delegates or alternate delegates to MAG and thus have a voice in the MAG House of Delegates. Therefore, the Committee determined that its recommendation to Executive Committee on establishment of a Business Session for Interns and Residents would be as follows:

1. The committee recommended against establishment of a Business Session for house staff. Since these physicians are eligible for membership in the MAG, special consideration should not be required at the MAG House of Delegates level.

2. The County Medical Societies should be strongly encouraged to obtain the active participation of house staff in the County Medical Society. The County Medical Society should be urged to provide full membership by including the house staff in all of their meetings and appointments to their committees and allowing them to be nominated to serve as officers of the societies including delegates and alternate delegates to the MAG.

These recommendations were adopted by Council.

Just as the house staff has specific needs for information about socio-economic matters, on a more general level the medical students also would be well served by MAG if general socio-economic topics of discussion could be presented to them. MAG should make a greater effort to provide such programs to both house staff and students.

In discussing the necessity for a business session for students at the MAG House of Delegates, the Committee concluded that some special consideration should be made for students, since they could not be full members of MAG until they become physicians. Because they do have representation at the House of Delegates by non-voting delegates, it was suggested that there would be opportunity for these individuals to represent the students at the MAG Annual Session.

The committee, therefore recommended:

1. No Business Session should be established for medical students.

2. The two American Student Medical Association

chapters should be encouraged to present reports, resolutions and recommendations to the MAG. The committee recommends that these be submitted to the MAG Committee on Education's Subcommittee on Medical Schools. The Subcommittee on Medical Schools should be used as the vehicle for presentation of reports, resolutions and recommendations to the MAG House of Delegates.

These recommendations were adopted by Council.

The committee discussed the use of travel funds made available by the Medical Association of Georgia to medical students of Emory and the Medical College of Georgia for travel to their ASMA meetings, as well as to the MAG House of Delegates meeting. The committee believed that the funds made available for this travel were sufficient. In addition to these travel funds, the committee felt that it might be worthwhile to allow students to travel to the AMA Annual or Clinical Meetings. It was the opinion of the committee that this would be a good opportunity to indoctrinate students in the affairs of AMA. It was suggested that a specific amount be set aside for travel and then the students who are interested in attending these meetings could use a portion of these funds, depending on how many individuals were to attend.

The committee therefore recommended:

1. MAG should set aside $300 for each ASMA Chapter at MCG and Emory. These funds could be used to cover the expenses of medical students who wish to attend the AMA meetings.

2. The committee further recommends that MAG should not fund house staff attendance at the AMA meeting as suggested by Dr. James Sammons' communication from the AMA at this time.

These recommendations were adopted by Council.

The committee felt that it might not be possible for these individuals to get away from their positions at the hospitals. Additionally, the opportunities for discussion at the AMA meetings might not be in the best interest of medical care back in Georgia. For example, the committee felt that discussion of the formation of labor unions by house staff would not be in the best interests of patient care.

The committee enthusiastically supported the continuation of the Practice Management Workshops sponsored by MAG and the AMA. It was suggested that the scheduling of these workshops be examined and the possibility of their being scheduled at both Augusta and Atlanta be considered. In addition, since this did provide a great service to house staff, it was the belief of the committee that the registration fee might be lowered for these meetings and that MAG pick up a greater portion of the cost of the meeting since this was the best service that could be provided by the Association to house staff.

The committee therefore recommended:

1. The committee sponsoring these workshops should consider the possibility of scheduling them in Augusta and Atlanta.

2. The managing committee should also consider the possibility of reducing the registration fee and requesting MAG Finance Committee to support these workshops to a greater extent through use of MAG funds.

These recommendations were adopted by Council.

The Ad Hoc Committee to Study Business Sessions for Interns/Residents/Students at MAG's Annual Sessions having completed its study and reported to the appropriate MAG governing bodies, has concluded its task and fulfilled the charge placed upon it by the Executive Committee.

AD HOC COMMITTEE ON CRITERIA DEVELOPMENT FOR HOSPITAL UTILIZATION REVIEW (C54)

Lee H. Battle, M.D.

MAG was asked by Blue Cross of Atlanta to review changes it was proposing for the Georgia Utilization Resources Material (G.U.R.M.) handbook. The Executive Committee reactivated the ad hoc Committee on Criteria Development for Hospital Utilization Review which had originally reviewed the G.U.R.M. handbook. The committee reviewed the changes in G.U.R.M. handbook, suggesting minor revisions. The MAG Executive Committee accepted the committee's recommendation and continued MAG's endorsement of the G.U.R.M. handbook.

The committee did not undertake any other activities during the past year.

RESEARCH AND DEVELOPMENT DIVISION (D3)

Earnest C. Atkins, M.D.

The Research and Development Division of the Medical Association of Georgia has a number of ongoing programs and projects which are described below.

QUALITY ASSURANCE CONSULTATION PROJECT

This project, in its third year of funding by the Georgia Regional Medical Program, continues to provide assistance to hospitals in implementing quality assurance programs. The four-day seminars offered this year give medical audit and nursing audit committee assistants intensive training in the basic principles and methods of retrospective patient care evaluation through lectures, discussions, and exercises. Individualized consultations, available to any hospital in Georgia upon request, provide on-site assistance to medical staff and hospital personnel in their local setting.

The project also serves as a clearinghouse for patient care evaluation information for the state, as well as other parts of the country. In addition to the activities described above, this is accomplished through the monthly newsletter "Audit Specs," a criteria bank, a reference library, and an audit critiquing service. Project staff provide assistance to members of the Education Committee studying the relationship between patient care evaluation and continuing medical education as well as the Joint Georgia Hospital Survey Project Committee. In March, the project sponsored a one-day visit by Dr. Richard E. Thompson, from the Illinois Hospital Association, formerly of The Medical Center, Columbus. Dr. Thompson met with various groups to discuss patient care evaluation and continuing medical education.

During its three years of existence, this project has been a valuable and unique resource in the evolving area of patient care evaluation and has offered special educational opportunities that otherwise would have been unavailable in this state. Alternative sources of

funding are being investigated so that project activities may be continued when the current year of funding ends June, 1977.

GEORGIA CANCER REGISTRY

The Georgia Cancer Registry operated by MAG's Research and Development division since 1974, is under contract with the Georgia Department of Human Resources to collect statewide cancer data from twenty participating hospitals. In addition to computer services, on-site and telephone consultations are available with emphasis placed on meeting requirements of the American College of Surgeons for accreditation of the hospital cancer program.

Educational seminars are conducted for the benefit of participating hospitals and other interested persons. These programs stress the importance of collecting and maintaining high quality data to meet the criteria for an Approved Hospital Cancer Program.

A supplemental appropriation of $18,000 has been received to permit continued operation of this repeatedly under funded project until funding for the new fiscal year can be made available July 1, 1977.

PROGRAM TO IMPROVE HEALTH CARE IN JAILS

The Medical Association of Georgia has been awarded $30,000 by the Law Enforcement Assistance Administration for the second of a three-year program to improve health care in jails. Through data collected in the program, plans are to: develop health care training programs for appropriate jail personnel and to test standards leading to the development of a statewide certification program. Activities of the project are expected to involve local medical societies in supportive and technical roles.

INFORMATION SYSTEMS

The data processing function at MAG, which was begun to meet the needs of the EMCRO project, has grown to a staff of four computer professionals, and provides data processing services to virtually every department of the Association.

An arrangement with Emory University allows the Medical Association to buy computer time from them at a very low cost. The Emory computer is accessed through computer terminals owned by Emory but located in the MAG headquarters building. In addition, "intelligent terminal" equipment allows the various departments within MAG to have their own computer terminals and permits a limited amount of data processing independent of the Emory computer.

The staff now handles at a saving in total cost the computer services for CHAMPUS, a function previously handled by outside service organizations. Functions formerly done by hand, such as membership accounting and payroll processing, have been computerized.

During the coming year, the Information Systems staff will operate the existing computer projects, and will develop for the Foundation a computerized index system. This system will allow them to microfilm most documents relating to medical care review, greatly reducing storage requirements, while still permitting any given document to be located within seconds with the aid of the computer.

New Business

The Speaker proceeded to new business, calling for the introduction of resolutions. The following resolutions were then presented:

Use of Drugs by Optometrists (R1)—Reference Committee C
Unified Membership (R2)—A
Cost of Publishing the *Journal of the Medical Association of Georgia* (R3)—F
Printing and Stationery Services to Membership (R4)—A
Geographical Fee Determination (R5)—C
Catastrophic Health Insurance (R6)—C
Minimum Standards for Health Insurance (R7)—C
Composite Board of State Medical Examiners (R8)—C
Medicaid in Georgia (R9)—C
Preadmissions Screening (R10)—B
Reforms in the Medicaid and Medicare Laws (R11)—C
Malpractice Legislation (R12)—C
Freedom of Choice in Direct Billing (R13)—B
Right of Referendum and Petition (R14)—Constitution and Bylaws
Study and Evaluate Medicaid (R15)—C
Anti-Smoking Campaign (R16)—D
Expansion of Family Practice Training (R17)—D
National Health Insurance Survey (R18)—C
Redefinition of Associate Membership (R19)—Constitution and Bylaws
Repeal of Chapter Eight Section Two—Unified Membership (R20)—A
Saccharin (R21)—B
Health Education in Schools (R22)—B
County Medical Society Project in Health Education (R23)—D
Affiliate Membership (R24)—A
Physician Recruitment by Hospitals (R25)—B
Unified Membership (R26)—A
GSRO Planning Contracts (R27)—D
AMA Membership Opinion Poll Regarding National Life Insurance (R28)—B
Objection to Saccharin Ban (R29)—D
Energy Conservation (R30)—C
Geographical Fee Determination (R31)—C
Association Finances (R32)—A
Medical Ethics (R33)—A
Laboratory Charges (R34)—A
Investigation of MAG Organization (R35)—A

The Speaker then adjourned the first session of the House of Delegates at 12:30 p.m.

One copy of the 1977 Roster will be mailed to each active member of the Medical Association with the August issue of the **Journal.**

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office will be available by advanced order for $5 a copy. Non-members will pay $10 for the first and every additional copy.

Checks should be made payable to the Medical Association of Georgia. Copies that have been ordered in advance will be mailed out at the end of August.

1977 ROSTER ORDER FORM

Medical Association of Georgia

938 Peachtree Street, N.E.

Atlanta, Georgia 30309

Att.: Sharon Smith

MEMBERS ONLY: $5 (for second and above copies)

Enclosed is $..... for ..... rosters

NON-MEMBERS: $10 per copy

Enclosed is $ ..... for ..... rosters

Name: .....

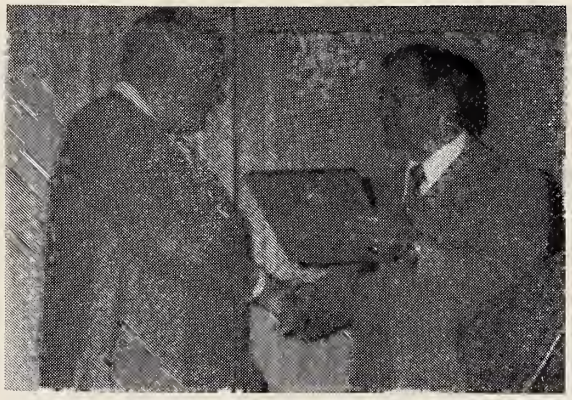
Address: .....

.....

City **State** **Zip**

GaMPAC *Brunch* 1977









The Fourth Annual GaMPAC Brunch was held in the Grand Ballroom of the Macon Hilton Hotel at 10:30 a.m. on Saturday, April 23, 1977.

The affair was kicked off by a champagne cocktail hour proceeded by a buffet brunch.

J. Daniel Bateman, M.D., Albany, chairman of the Georgia Medical Political Action Committee, introduced those seated at the head table: Robert E. Perry, M.D., MAG president-elect; Alice Carol Perry; Fleming L. Jolley, M.D., MAG president; Anne Jolley; Mrs. Mary Ellen Bateman, co-chairman of GaMPAC; Earnest C. Atkins, M.D., secretary-treasurer of GaMPAC, and Marianna Atkins.

Other distinguished guests included William H. Cooper, M.D., board of directors of AmPAC; Peter B. Lauer, political educational coordinator for AmPAC; Speaker Tom Murphy of Bremen; Rep. Wilbur Baugh, M.D., of Milledgeville; Rep. Bobby Parham, Milledgeville, and Rep. J. Roy Rowland, M.D., of Dublin.

Honored guest speaker was Mr. Jerry Toman. Mr. Toman addressed the group as a political analyst with a satirical view on how effective medicine is in politics. His additional humorous cast-off remarks about certain political figures, both nationally and locally, as well as those about certain people in the audience drew much attention and response.

Special recognition was given to Dr. Earnest C. Atkins as he was presented an award for his outstanding and dedicated service to the organization over the past 14 years. This was the first such award in GaMPAC history.

Dr. Bateman presented Certificates of Appreciation to Speaker Tom Murphy, Rep. Wilbur Baugh, Rep. Bobby Parham, and Rep. J. Roy Rowland, M.D.



Top to bottom: Mrs. Marianna Atkins, Dr. Earnest Atkins and Mrs. Mariellen Bateman; Dr. J. Dan Bateman (right) presents a special award to Dr. Atkins for his outstanding service to GaMPAC; MAG staff members Jo Hogan and Rusty Kidd serve champagne before the brunch; Guest speaker Jerry Toman; guests help themselves at the buffet table.

Second Session House of Delegates

Saturday, April 23, 1977

THE SECOND SESSION of the House of Delegates, Medical Association of Georgia, 1977 Annual Session Business Meeting was called to order at 1:30 p.m. on Saturday, April 23, 1977, by Speaker L. C. Buchanan, Decatur, in the Grand Ballroom of the Hilton Hotel, Macon, Georgia.

Speaker Buchanan asked for a report on attendance from Dr. Hugo S. Moreno, Chairman of the Credentials Committee, and it was reported that 162 duly elected delegates representing 47 component medical societies were present for the Second Session.

Reference Committee Reports

Speaker Buchanan called for reports from the Reference Committee Chairmen. The Speaker restated the procedure that would be followed and then proceeded to call for reports from reference committees in the following order:

REPORT OF REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

F. G. ELDRIDGE, M.D., Chairman
DAVID M. BOYETTE, Vice Chairman

Chairman Eldridge reported that the Reference Committee on Constitution and Bylaws had given careful consideration to all the items referred to it as it met in session on Friday, April 22, 1977, at the Hilton Hotel in Macon, Georgia.

Members of the Reference Committee present included F. G. Eldridge, M.D., Chairman, Valdosta; David M. Boyette, M.D., Vice Chairman, Albany; Robert J. Moye, M.D., Swainsboro; Edmund M. Molnar, M.D., Columbus; L. Astin Flint, M.D., Canton, and William D. Spearman, M.D., Atlanta.

NOTE: Existing wording appears here as is. Suggested amendments by **addition** are indicated by **boldface type.** Amendments by *deletion* are indicated by *italicized type.* It is possible to read the wording as it is suggested. Only those sentences preceding and succeeding a suggested change that help identify the suggested amendments are shown here.

COMMITTEE ON CONSTITUTION AND BYLAWS (C9)

John T. Mauldin, M.D.

The House of Delegates, in April of 1976, adopted two recommendations for amendments to the C & B of the ad hoc Committee on Organizations and Functions. The actual amendments are presented here for the consideration of the 1977 House of Delegates.

Item 1: Change of name from Council to Board of Directors.

GENERAL AMENDMENT TO CONSTITUTION

The words "Council," "Councilor(s)" and "Vice Councilor(s)" shall be stricken whenever and wherever they occur in this Constitution, and the words "Board of Directors," "Director(s)" and "Alternate Director(s)," respectively, shall be inserted in place of the stricken terms.

GENERAL AMENDMENT TO BYLAWS

The words "Council," "Councilor(s)" and "Vice Councilor(s)" shall be stricken whenever and wherever they occur in the Bylaws, and the words "Board of Directors," "Director(s)" and "Alternate Director(s)," respectively, shall be inserted in place of the stricken terms.

Association legal counsel has determined that these two general amendments are quite sufficient to effect the name change in the C & B as adopted by the 1976 House of Delegates.

It is also the opinion of counsel that the 1977 House

of Delegates will be able to take final action on the Constitution Amendments above. In brief, counsel feels that the Constitutional requirement "that proposed Amendment be introduced in the previous session and provided that the proposed amendment shall have been published during the year in the JMAG will have been met as the result of the 1976 House adopting the "intent" to change the name and this Action reported in the Proceedings issue of JMAG. The actual wording of the Amendment need not be introduced and "lay on the table."

RECOMMENDATION

The Committee on Constitution & Bylaws recommends the adoption of the amendments to the Constitution and Bylaws changing the name of Council to Board of Directors.

REFERENCE COMMITTEE RECOMMENDATION

(1) Item 1 proposes to amend the Constitution and Bylaws to change the name of Council to the Board of Directors. The Committee understands that the general amendments to the Constitution and Bylaws as provided by the Committee fulfilled the requirements of the Constitution and the Bylaws and are acceptable to amend these documents.

Mr. Speaker, your Committee recommends the adoption of the general amendment to the Constitution.

HOUSE OF DELEGATES ACTION—Adopted.

Item 2: Election of Councilor and Vice Councilor by Mail Ballot.

The 1976 House of Delegates directed that this Committee prepare necessary Amendments to **permit** the election of Councilors and Vice Councilors by mail ballot on an optional basis and to prepare Amendments to remove any prohibition to mail ballots. The Committee finds no such prohibition, therefore the following proposed amendment will, if adopted, permit mail ballots on an optional basis.

CHAPTER VI
ELECTION OF COUNCILORS AND
VICE-COUNCILORS

Section 3. **(a)** The terms of Councilors and Vice-Councilors. District Societies and component medical societies entitled to direct representation by one or more Councilors and Vice-Councilors, shall in appropriate years, according to the terms of their respective Councilor and Vice-Councilor elect Councilors and Vice-Councilors at their annual meeting **or by an election conducted by mail. Elections conducted by mail must take place prior to the annual meeting of the District Society and utilize a procedure approved in advance by the MAG Council.** The Secretaries of such Societies. . . .

Section 3 **(b)** "If a Councilor dies. . . ."

RECOMMENDATION—No recommendation by the committee.

REFERENCE COMMITTEE RECOMMENDATION

(2) Election of Councilor and Vice Councilor by mail ballot. The Committee feels that the election by mail ballot of the Councilor and Vice Councilor by the District Medical Societies is an appropriate procedure and the proposed amendment makes this procedure available to the county medical societies.

Mr. Speaker, your Committee recommends the adoption of Item 2 which amends the Bylaws, Chapter VI, Section 3.

HOUSE OF DELEGATES ACTION—Adopted with amendment to the last line Item (2) of the Reference Committee Report insertion "District and" before county medical societies.

Item 3. Two Bylaws Amendments for clarification are needed.

CHAPTER V
COUNCIL

Section 2. Chairman and Secretary. The Secretary of the Association shall serve as Secretary to the Council. The Council may designate the Executive Director *or Associate Director* to serve in this capacity.

Note: The staff position of Associate Director no longer exists.

REFERENCE COMMITTEE RECOMMENDATION

(3) This is a proposal to amend Chapter V, Section 2 of the Bylaws by deleting the title of Associate Director, a title which is no longer in the staffing pattern of the Headquarters Office.

Mr. Speaker, your Committee recommends the adoption of this amendment to Chapter V, Section 2.

HOUSE OF DELEGATES ACTION—Adopted.

Section 3. Executive Committee. The Executive Committee shall be composed of the President, who shall serve as Chairman of the Executive Committee, the President-Elect, the Immediate Past President, the First Vice-President, the Secretary, the Treasurer, the Chairman of Council, who shall serve as Vice-Chairman of the Committee *and the Chairman of the Committee on Finance*. The Second Vice-President. . . .

Note: The Treasurer is the Chairman of the Finance Committee and is already specified as a member of the Executive Committee. There does not now exist a Chairman of the Committee on Finance other than the Treasurer.

RECOMMENDATION—Adoption.

REFERENCE COMMITTEE RECOMMENDATION

Item 3 also proposes to amend Chapter VI, Section 3, by deleting the office of the "Chairman of the Finance Committee" from the membership of the Executive Committee since the Chairman of the Finance Committee is now the Treasurer.

Mr. Speaker, your Reference Committee recommends adoption of this amendment to the Bylaws, Chapter V, Section 3.

HOUSE OF DELEGATES ACTION—Adopted.

Item 4. On adopting the report of the President-Elect, the 1974 House of Delegates instructed the Committee to prepare language to 1) set maximum limit for unbudgeted expenditures by Council, 2) reconstitute the Committee on Finance as a Committee

REFERENCE COMMITTEE ON C & B

of the House of Delegates rather than Council, and 3) to authorize the Finance Committee to approve the Council expenditures beyond the limitations set for the Council.

As directed, the Constitution & Bylaw Committee presented the language to accomplish these amendments to the 1975 House of Delegates. This Committee strongly disapproved of this change in the structure of the Association and the House of Delegates Reference Committee, concurring in this opinion, recommended that the amendments be **not** adopted. The 1975 House of Delegates, in its wisdom, did not adopt the amendments but referred the proposal back to the Executive Committee, thence to the Constitution & Bylaws Committee, and subsequently to the 1976 House of Delegates. Since the Constitution & Bylaws Committee had performed the task of preparing the appropriate language as directed by the House, the Committee sought the further direction of the Executive Committee as to how it should proceed. In a meeting on November 23, 1975, the Executive Committee passed a series of motions which still left the Committee unsure of the direction it should take in complying with the wishes of the House and the Executive Committee.

In its best judgment, the Constitution & Bylaws Committee responded to the January 10 and 11, 1976 Council meeting as directed with language to 1) set a maximum limit for expenditure of unbudgeted funds, and 2) set up a mechanism for approval of expenditures of amounts over-budget. Because of a series of unclear motions passed by the Executive Committee, it was the committee's judgment, **at that time,** that this was all it was being asked to do, plus other unrelated items. The current judgment of the Executive Committee is that the question of the reconstitution of the Finance Committee as a committee of the House should, in fact, be brought before the House for its consideration. The appropriate language to accomplish this follows.

Note: No. 1 above was defeated by the 1976 House of Delegates, therefore negating the need for No. 2. These sections are not treated in the proposed language that follows.

CONSTITUTION
ARTICLE VI
COUNCIL

Section 2: Duties. The Council has charge of all property and financial affairs of the Association **consistent with the limitations imposed by the Finance Committee** of the House of Delegates, and perform such duties as are prescribed by law governing directors of corporations as may be prescribed in the Bylaws.

ARTICLE X
Funds & Expenditures

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component Society. The amount of assessment shall be set by the House of Delegates upon recommendations of Council. Funds may also be raised by voluntary contributions from the Association's publications, and in any other manner approved by the Council. The *Council* **Committee on Finance shall, with recommendation of Council,** submit an annual budget to the House of Delegates **and the Council** shall manage the finances of the Association **consistent with the limitations imposed by the Finance Committee of the House of Delegates.**

BYLAWS
CHAPTER IV
House of Delegates

Section 9. Committee on Finance

a. Composition. The Committee on Finance shall be composed of five members of which the Treasurer of the Association shall be one and serve as Chairman. The House of Delegates will annually elect the remaining four members as provided in these bylaws (Chapter VI-Section 2.

b. Duties. (1) Each committee of the Association shall submit its budget to the Committee on Finance at such time as the Committee on Finance may designate. (2) It shall be the responsibility of the Committee on Finance to propose an annual budget for the Association for the fiscal year beginning June 1 and ending May 31 of the following calendar year. (3) The annual budget proposed by the Committee on Finance shall be submitted to the Council for its consideration and recommendation to the House of Delegates at the last meeting prior to the annual session of the House of Delegates. (4) The House of Delegates shall approve the annual audit of all Association accounts.

CHAPTER VI
OFFICERS OF THE ASSOCIATION
AND THEIR ELECTION

Section 4. Committee on Finance. Each member shall serve for one year and shall be eligible for re-election to succeeding terms. Nominations for candidates and their election will be in the same manner as prescribed in these bylaws for the nominations and election of the officers of the Association. (Chapter VI —Section 2.)

CHAPTER V

Section 9. Committee on Finance. The treasurer shall serve as chairman of the committee on finance. The Chairman of the Council shall appoint from among its members a committee of three members to be known as the Committee on Finance, which shall cause to be audited all accounts of the Association. The Committee shall propose an annual budget for the fiscal year beginning June 1, and running through May 31. Such budget shall be subject to modification and approval of the Council. Each Committee shall submit to the Committee on Finance its budget for the following fiscal year at such time as the Committee on Finance may designate. This proposed budget shall be prepared by the Committee on Finance for the consideration of the Council at the last meeting in the last quarter of each fiscal year. This budget shall be presented to the House of Delegates for its approval. It shall also submit an annual report to the House of Delegates which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

All expenditures made by the Local Arrangements Committee in connection with the Annual Session must be authorized in advance by the Committee on Finance. Council shall have control of all commercial

exhibits at the Annual Sessions and any deficit created on account of the Annual Session shall be met by Council on recommendation of the Committee on Finance.

Section 5. General Duties

a. The Council shall be the executive body of the House of Delegates. . . .

b. The Council shall provide such headquarters for the Association. . . .

c. The Council shall by appointment fill any vacancy. . . .

d. The Council shall review the Annual Budget proposed by the Committee on Finance and make recommendations to the House of Delegates.

e. The Council shall authorize the payment of all necessary expenses incurred by the Officers. . . .

f. The Council shall submit an annual report to the House of Delegates which shall specify the Character of all its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

CHAPTER X
COMMITTEES

Section 1. Standing Committees. . . . **(G) COMMITTEE ON FINANCE (See Chapter IV Section 9)**

RECOMMENDATIONS

As when this proposal was originally introduced, the Committee on Constitution & Bylaws strongly recommends that these amendments **be not adopted** on the grounds that:

1. The Committee on Finance, as a committee of Council, has worked well for many years and has served the needs of the Association in a most efficient manner.
2. Council is more representative of the physicians across the state than would be a five-member finance committee and therefore it would be better able to reflect the wishes of the membership as a whole.
3. The present system is more flexible and in a better position to respond in a timely manner to any unusual contingencies that may arise.
4. The sheer numbers of the House of Delegates would preclude the proper consideration of candidates so that delegates could cast an informed vote.
5. The additional time required to nominate and elect four additional officers would substantially detract from the time available for the House to consider the pressing issues confronting medicine.
6. Further fragmenting of the Association's decision-making process would hinder the prompt response to current situations.

REFERENCE COMMITTEE RECOMMENDATION

(4) This item proposes various amendments to the Constitution and the Bylaws that would make the Finance Committee a Committee of the House of Delegates.

In its report, the Committee on Constitution and Bylaws opposes this for a number of reasons. Mr. Chairman, your Committee cannot improve on the reasons provided by the Constitution and Bylaws Committee.

Mr. Speaker, your Reference Committee recommends that the amendments proposed in Item 4 be not adopted.

REFERENCE COMMITTEE ON C & B

HOUSE OF DELEGATES ACTION—Not adopted.

Item 5. At the time the House of Delegates divided the Annual Session, separating the business session of the House of Delegates from the scientific activities, the Bylaws were not adjusted to accommodate this change. Chapter III in the Bylaws, entitled General Meetings, deals with the procedure for the old Annual Session and does not reflect the current procedure.

The Committee on Annual Session presently concerns itself with the arrangements for the Annual meetings of the House of Delegates. The following proposed amendments have been prepared to establish the mechanism to handle the Scientific Assembly as it is presently constituted.

Presented here are two separate proposals designated 5A and 5B. Proposal 5A is submitted as the recommendation of this Committee on the grounds that Bylaws should be brief, concise and contain only the essentials necessary to accomplish the desired result. It has been our experience that when Bylaws are overly detailed, the activity is restricted and does not allow for adaptation to current trends without the continuous necessity for Bylaw Amendment. The Committee also believes that **all** MAG Committees should carry out the policies of the Association as determined by the House of Delegates and directed by Council. The appointment process of the members of each committee should be consistent.

Proposal 5B is submitted by the Committee on Scientific Assembly as their recommendation. While the Committee on C & B has no disagreement with the Committee on Scientific Assembly over what it wishes to accomplish with their proposal, it does feel that the detail they propose for Bylaw language would be better as a recommendation to the House of Delegates for adoption as policy of the Association to be administered and interpreted by the Council. This mechanism would be far less cumbersome than amending the Bylaws continually.

PROPOSAL 5A
CHAPTER X
COMMITTEES

Section 1. Standing Committees. The standing committees of the Association shall be as follows:

G. Committee on Scientific Assembly

SECTION 8. COMMITTEE ON SCIENTIFIC ASSEMBLY

a. Purpose

The Committee shall conduct such general scientific meetings as it considers beneficial to the membership of the Medical Association of Georgia and the medical profession as a whole in the State of Georgia, consistent with the affirmed policies of the Association as directed by Council and the House of Delegates. The Committee shall submit a budget for these general scientific meetings to the Finance Committee.

b. Composition

The Committee shall consist of a Chairman, appointed annually by the Executive Committee, and by reason of their offices, the current Chairman of the Interspecialty Council and the Committee on Education.

CHAPTER III
GENERAL MEETINGS

Section 1. General meetings of the Association shall be open to all members and guests, provided they have complied with the registration requirements. *These meetings shall be presided over by the President or Vice President.*

Delete in toto Sections 2, 3, 4, 5, 6, and 7.

Section 2. Lectureships for presentation at general scientific meetings may be established by interested donors honoring distinguished deceased members or former members of the Medical Association of Georgia or honoring someone not a former member or physician who has rendered distinguished service to the Medical Association of Georgia or of Georgia medicine. Each lectureship must be approved by the Board of Directors and established by setting up a trust fund which shall be in accordance with the present pattern of the lectureship trust fund. A representative of the lectureship trust fund, who must be a member of MAG, shall be invited by the Committee on Scientific Assembly to submit suggestions concerning the choice of speakers for the lectureship.

PROPOSAL 5B
CHAPTER III
GENERAL **SCIENTIFIC** MEETINGS

Section 1. The general scientific meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the *President or Vice President.* **Chairman of the Committee on Scientific Assembly.**

Sections 2, 3, 4, 5, 6, and 7—Delete in toto **and insert the following.**

Section 2. The programs for the general scientific meetings shall be prepared by the Committee on Scientific Assembly and published in an issue of the Journal preceding the meeting.

Section 3. The Committee on Scientific Assembly shall nominate a new chairman each year, subject to approval by the Executive Committee. The chairman must have served on the committee for at least one year. By reason of their offices, the chairmen of the Interspecialty Council and the Committee on Education shall serve on the Committee on Scientific Assembly.

Section 4. The Committee on Scientific Assembly shall select the date and site of each general scientific meeting far enough in advance to allow for adequate program planning and the making of hotel reservations.

Section 5. Any medical specialty society represented on the Interspecialty Council may participate in planning programs for the general scientific meetings. Other specialty groups may participate in program planning only with the approval of the Committee on Scientific Assembly. Educational funds may be budgeted and paid by the MAG only to specialty societies represented on the Interspecialty Council which have responsibility for planning programs in the various scientific sections. Such reimbursements shall be based upon actual attendance at the sectional programs. Specialty groups not represented on the Interspecialty Council may apply for educational funds and will receive them only with special approval of the Committee on Scientific Assembly and the Board of Directors.

Section 6. Lectureships for presentation at general scientific meetings may be established by interested donors honoring distinguished deceased members or former members of the Medical Association of Georgia or honoring someone not a former member or physician who has rendered distinguished service to the Medical Association of Georgia or to Georgia medicine. Each lectureship must be approved by the Board of Directors and established by setting up a trust fund which shall be in accordance with the present pattern of the lectureship trust fund. A representative of the lectureship trust fund, who must be a member of MAG, shall be invited by the Committee on Scientific Assembly to submit suggestions concerning the choice of speakers for the lectureship.

REFERENCE COMMITTEE RECOMMENDATION

(5) This item proposes several amendments that would, in effect, bring the Bylaws into line with the actual practices relative to the operation of the Committee on Scientific Assembly. Two proposals were offered. One, Proposal 5A, by the Committee on Constitution and Bylaws which would make the Committee on Scientific Assembly a standing committee and proposes a general outline for the Committee on Scientific Assembly and the Scientific Assembly activities.

Proposal 5B is offered by the present Committee on Scientific Assembly and the Interspecialty Council. This proposal is a detailed outline of the activities of the Scientific Assembly and the Committee on Scientific Assembly. Your Reference Committee felt that Proposal 5A would be the more appropriate mechanism.

Therefore, Mr. Speaker, your Reference Committee recommends the adoption of the various amendments as proposed in proposal 5A.

HOUSE OF DELEGATES ACTION—Adopted Proposal 5A.

Item 6. It has come to the attention of the committee that the Women's Auxiliary has changed its name. This proposed Bylaw Amendment will recognize that change.

CHAPTER X
STANDING COMMITTEES

Section 1. (D) Committee on *Women's* Auxiliary

Section 5. Committee on *Women's* Auxiliary. The Committee on *Women's* Auxiliary shall. . . .

RECOMMENDATION—Adoption.

REFERENCE COMMITTEE RECOMMENDATION

(6) This item recognized the change in the name of the Auxiliary from the Women's Auxiliary to the Auxiliary of the Medical Association of Georgia.

Mr. Speaker, your Reference Committee recommends the adoption of item 6.

HOUSE OF DELEGATES ACTION—Adopted.

RESOLUTION 14
RIGHT OF REFERENDUM AND PETITION

W. Daniel Jordan, M.D.
Medical Association of Atlanta

WHEREAS, it is appropriate for the membership of the Medical Association of Georgia to have suitable mechanisms to express its opinion to both the leadership of MAG and to the public, therefore be it

RESOLVED, that the House of Delegates of MAG in Annual Session in April, 1977 accept the following as a proposed amendment to the Constitution of the Medical Association of Georgia:

ARTICLE XIV

The right of referendum and petition shall be as set forth in the Bylaws of the Medical Association of Georgia.

And, be it FURTHER RESOLVED, that the House of Delegates of MAG in Annual Session in April, 1977, instruct the Constitution and Bylaws Committee to develop a provision within the Bylaws of MAG to accomplish the above resolved, requiring signatures of at least 10% of the membership and requiring suitable geographic representation of the petitioning members.

REFERENCE COMMITTEE RECOMMENDATION

Your Reference Committee felt that the concept of petition and referendum as proposed by this resolution has merit. However, the resolution is vague and ambiguous and the actual mechanism needs more study development before an informed decision can be made.

Mr. Speaker, your Reference Committee recommends that Resolution 14 be referred to the Committee on Constitution and Bylaws for further study and recommendation.

HOUSE OF DELEGATES ACTION—Voted to refer as recommended by the Reference Committee.

RESOLUTION 19
REDEFINITION OF ASSOCIATE MEMBERSHIP

Medical Association of Atlanta

WHEREAS, organized medicine would be greatly benefited by the active participation of state and county health officers and members of full-time medical faculties,

NOW, THEREFORE, BE IT RESOLVED that Chapter II Section 4 of the MAG Bylaws be amended to strike State and County Health Officers and full-time members of medical schools from the category of Associate Membership so that this section would then read in its entirety:

SECTION 4. ASSOCIATE MEMBERS. A physician may be granted Associate Membership *if he is engaged in State or County Medical services or if he is a full-time salaried member of an approved medical faculty in this state* or who is an intern or resident in a hospital whose internship program is approved by the State Board of Medical Examiners **and to other physicians who are recommended by their county medical societies and approved by the Executive Committee of MAG.** An Associate Member need not be licensed to practice medicine in the State of Georgia. Associate Membership, except as otherwise provided herein, also may be granted to a member of a component medical society. Associate Members shall pay no dues and shall not be entitled to vote or hold office, nor shall they be entitled to receive any publication of the Association except by personal subscription.

REFERENCE COMMITTEE RECOMMENDATION

Resolution 19 would amend the Bylaws to exclude state and county health officers and full-time members of medical school faculties from Associate membership. It would require these categories to be active members. The Committee agrees in principle with the concept that these categories of physicians should be active MAG members.

Mr. Speaker, your Reference Committee recommends that Resolution 19 be referred to the Committee on Constitution and Bylaws for their consideration and development of the appropriate wording to accomplish the principle set forth in the Resolution.

HOUSE OF DELEGATES ACTION—Voted to refer Resolution 19 to the Committee on Constitution and Bylaws for consideration and development of appropriate wording.

Chairman Eldridge expressed his appreciation to the members of the Reference Committee and thanked all those who appeared before the Committee to express their views and to staff for their help in the preparation of this report.

REFERENCE COMMITTEE F

REPORT OF REFERENCE COMMITTEE F

H. DUANE BLAIR, M.D., Chairman

Chairman Blair reported that members of Reference Committee F met in the Mulberry Room, Macon Hilton Hotel, on April 22, 1977, and carefully considered all of the items referred to the Committee.

Members of the Reference Committee present included: H. Duane Blair, M.D., Decatur, Chairman; G. Lester Forbes, M.D., Atlanta; Stuart H. Prather Jr., M.D., Augusta; J. Gary Palmer Jr., M.D., Marietta; Rupert H. Bramblett, M.D., Cumming, and Cyler D. Garner, M.D., Gordon.

RESOLUTION 3
COST OF PUBLISHING THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA

Harvey M. Newman, M.D.
Hall County Medical Society

BE IT RESOLVED that the House of Delegates, Medical Association of Georgia, shall direct that a less expensive format be required in the printing and publication of the Journal of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION

Having heard extensive testimony, your Committee feels that the quality of the format of the Journal of the Medical Association of Georgia is satisfactory and reasonable in cost.

Mr. Speaker, your Committee recommends that Resolution 3 be not adopted.

HOUSE OF DELEGATES ACTION—Voted to not adopt Resolution 3.

DISABLED DOCTORS COMMITTEE (C12)

G. Douglas Talbott, M.D.

INTRODUCTION

This report concerning the Disabled Doctors Program of Georgia is submitted to the Medical Association of Georgia's Annual Meeting. The program marks its 17th month of operation since its inception in the fall of 1975.

HISTORY

In September of 1975, the Medical Association of Georgia's Disabled Doctors Program officially became funded and operational throughout the state of Georgia. A start-up time of approximately nine months encompassing the first part of 1975 had been utilized by the individuals involved in the Medical Association of Georgia's Disabled Doctors Program to develop and refine the system so that it might be ready by September of 1975 for initiation of operations. For the past year the Disabled Doctors Program has been operating throughout the state of Georgia. There have been some procedural changes in the operation of the plan as experience has dictated. However, the program has now settled into a standard procedure which varies only as special circumstances dictate. Of historical significance in terms of improving and developing to a high degree the efficiency of the plan, has been the participation of Dr. Cullen Richardson as Chairman of the Disabled Doctors Committee. He has spent many hours of his time dealing with staff and individuals in the Disabled Doctors Program to provide both leadership and guidance, not only to the staff, but to the disabled doctors who are either beginning the program or who have required help in completing the program.

Phase I consists of 28 days or longer of treatment at an inpatient rehabilitation center.

Phase II consists of a 28 day outpatient program at the DeKalb Addiction Clinic in DeKalb County. Its program was developed, designed, and refined by the Program Chairman of the Physician's Consultant Committee with the help of several participating physicians in this program. This outpatient program is based upon the disease concept and emphasizes education and insight therapy, as well as spiritual retraining.

Phase III and IV consists of two months of staff training. This occurs in a variety of facilities including Unit III of Georgia Mental Health Institute, the Salvation Army, St. Jude's Halfway House, and other alcohol and drug rehabilitation centers. Several of the physicians have attended training seminars on alcohol and drug addiction in other states. Throughout Phase III and IV the physician participates in the weekly ongoing activities of the Disabled Doctors Program and is in constant physical contact with other members of the program. At the end of four months the physician returns to his or her practice, but remains involved in the weekly activities.

CADUCEUS CLUB

After completion of the four months' treatment program of the Disabled Doctors Program, all graduates enter into the Caduceus Club. This is a name given to the organization of disabled doctors and their spouses who have either completed treatment in the Disabled Doctors Program or who have joined the Caduceus Club. It is the name of the organization for those physicians in the state of Georgia who have successfully recovered from the disease of alcoholism, drug addiction, or psychiatric disorders. The club meets every Thursday night in a closed meeting for physicians, and their spouses or significant others. In January of 1977 at Unicoi State Park, approximately 45 members of the Caduceus Club spent the weekend in an educational, social weekend meeting.

WEEKLY ACTIVITIES

There are three major weekly activities of the Disabled Doctors Program of Georgia:

1. Therapy Group—On Thursday evenings, a senior group therapy leader, Mr. Wade Hopkin meets with a number of physicians in a closed therapy session. This is a closed group only to the physicians and the hour is utilized to explore the current problems, the situations, and emotional responses of physicians who are either currently in treatment or who are interested in continuing in the therapy group.

2. Thursday night is a meeting of the Caduceus Club where spouses, and significant others, as well as the disabled doctors meet. There is no set format. It is an educational, therapy, and social gathering that occurs on a weekly basis.

3. Every Wednesday at noon, six to eight Emory medical students meet with the Program Chairman and other physicians of the Disabled Doctors Program. The hour is utilized for teaching the students about the disease of alcoholism and drug dependence. In addition, the occupational hazard of physicians encountering the disorder of chemical dependence is stressed. Mutual dialogue teaching sessions make this a valuable session for both students and physicians.

PROGRAM ACTIVITIES

1. The International Doctors in A.A. had a meeting in Morristown, New Jersey which is the site of their annual gathering of the North New Jersey Professional Group. In 1976, twenty-two physicians and their wives from Georgia's Disabled Doctors Program attended this meeting.

2. The Disabled Doctors Plan has been presented to numerous medical societies, medical auxiliaries, and hospital staffs this year.

3. The Disabled Doctors Plan was presented to a convention of the National Council of Alcoholism in Washington, D.C. in May, 1976.

4. The Medical Association of Georgia co-sponsored with the American Medical Association a national conference, "The Impaired Physician: Answering the Challenge" on February 4-6, 1977 at the Hyatt Regency Hotel in Atlanta. Approximately 250 people attended the conference. There were many participants representing Georgia's Disabled Doctors Program, not only from the Medical Association of Georgia, but also from the Caduceus Club. Other participants in the conference expressed great interest in Georgia's program. It was evident that Georgia has the most developed and effective program represented at the conference and that Georgia's Disabled Doctors Program will become a model program for many other states.

RESULTS OF PROGRAM

The results to date of this program are summarized in the following chart:

Return to Practice	17
Currently in Treatment	4
Contacts	6
Participating Physicians	5
Broken Contracts	2
Deceased	1
Declined Contracts	9

It is significant at this point to point out that 17 physicians have been placed back in practice.

PRESENT PROGRAM STATUS

The track record and the response of the national medical community has demonstrated that the Medical Association of Georgia's Disabled Doctors Program possesses a unique national leadership role. However, our program has demonstrated experientially that we still have two basic needs:

1. We are in urgent need of a full-time physician to aid with this program. Disabled doctors can't reach out for help and we must go to them. It is now apparent that there are at least some 300 physicians who need counseling, help or treatment in the state of Georgia. Our experience has shown us that identification and motivation of these physicians requires that a trained, knowledgable physician spend a matter of a few days in each of the separate communities to motivate and find these doctors. It is not enough to have an excellent treatment program in Atlanta. One must motivate after having identified these physicians to come to this treatment center for the rehabilitation program. In addition, day to day treatment problems in Atlanta requires more help than the volunteers can provide which includes the Program Chairman. A knowledgable, trained physician is available and enthusiastic about filling the position at an annual salary of $33,000.00 per year.

2. We are also in need of a follow-up counselor to document and implement careful record keeping and data collection for our program and determine how the doctors are functioning at the present time to collect the necessary data. This person would also travel to the medical auxiliaries throughout Georgia to present the Disabled Doctors Program. Spouses in most cases are aware long before anyone else that their physician is in trouble. Such a person is available and well qualified. She is a nurse trained in addictive and psychiatric nursing who is experienced in working with the Disabled Doctors Program. She is also the wife of a doctor which would be helpful in dealing with the medical auxiliaries. Her salary on a 50% basis would be $6,500.00.

RECOMMENDATIONS

1. Funding for a full-time physician.
2. Funding for a half-time nurse.
3. Support of the budget as submitted for continuation of the Disabled Doctors Program.

REFERENCE COMMITTEE RECOMMENDATION

Expanding the services of the Disabled Doctors Committee by contracting for the services of a full-time physician, and contract funding of a follow-up counselor to document actions of the Committee by careful record keeping.

Recommendation 1—Funding for a full-time physician.

Mr. Speaker, your Committee recommends that funding for a full-time physician on a contract basis be adopted.

Recommendation 2—Funding for a half-time nurse.

Mr. Speaker, your Committee recommends that funding for a half-time nurse on a contract basis be adopted.

Recommendation 3—Support of the Disabled Doctors Committee Budget as submitted.

Mr. Speaker, your Committee offers the following amendment to Recommendation 3, "that the item monthly Newsletter, amount $2,000.00 be deleted, reducing the total budget to $56,800.00, since printing and publication facilities are available at MAG." Your Committee feels that the activities of the Disabled Doctors Committee should be closely monitored by Council and that a detailed report concerning this Committee's activities as well as a full financial report be presented to the House of Delegates in one year. Your Committee recommends that Recommendation 3 be adopted as amended.

HOUSE OF DELEGATES ACTION—Voted to adopt Recommendation 1 and 2 as ammended by the Reference Committee (funding on a contract basis), and voted to adopt Recommendation 3 which was an amendment to reduce the total budget by $2,000, thus deleting the requested monthly newsletter.

REFERENCE COMMITTEE F

COMMITTEE ON PROFESSIONAL LIABILITY INSURANCE (C44)

William W. Moore, M.D.

The committee has continued to monitor the status of the Professional Liability Insurance Program in Georgia, reviewing on an approximately monthly basis the new claims and reserves as they are reported. The number of claims per year continues to rise as illustrated:

	No. New Claims	*Increase of Reserves*
1974	195	
1975	312	$1.2 Million
1976	366	$2.3 Million

There are currently in excess of $8 million in outstanding reserves for Georgia cases.

The committee has acted in a consulting capacity with St. Paul in the evaluation of a number of claims and continues to do this in an effort to facilitate this difficult and very expensive problem. Several talks have been given to medical groups in an effort to help with an understanding of the claims made system and of the status of the program in relation to the rest of the country.

The pattern of premium structure is one that frequently changes but according to the best available information, the following premiums are in effect in Georgia and neighboring states:

	Class I	*Class VII*	
Georgia	$ 290	$ 2,048	
Alabama	416	2,670	
Florida	2,981	24,247	
Tennessee	400	3,125	
North Carolina	192	1,144	(St. Paul)
	967	7,827	(NCMS)
South Carolina	437	2,975	

In the entire 50 states, there were only three states lower than Georgia in Class One and four states lower than Georgia in the highest class.

The annual negotiation session regarding premium rates for the coming year will be taking place in late March, and the information from those meetings will be submitted as a late report. At the present time, on the basis of the continuation of increasing numbers and size of claims, it seems unlikely that a reduction of the scheduled increase of premium structure can be anticipated. By the same token, we do not anticipate that the scheduled increase in premiums for the third year of claims made experience will be any higher than that which was originally projected as given to the membership in previous mailings.

There have been some encouraging signs that the trend of increasingly poor experience is beginning to modify in a favorable fashion. Two major insurance companies who temporarily stopped coverage have reentered the market on a limited scale. The situation as regards excess coverage and reinsurance continues to worsen with both forms of coverage becoming scarce and expensive.

As a matter of information we are estimating that the total Georgia professional liability insurance premium for the coming year will approach $10,000,000.00. It follows then that a change of 1% in the premium could save or cost physicians $100,000.00 per year.

The vast majority of malpractice claims to arise from a milieu with the combination of poor understanding or communication between the doctor and patient and a bad result. Improved doctor-patient relationships and patient understanding of the bad results could materially affect our claims' experience and costs.

REFERENCE COMMITTEE RECOMMENDATION

C:44 A Professional Liability Committee Report Presenting New Professional Liability Insurance Rates for 1977-78.

Mr. Speaker, your Committee wishes to commend the Professional Liability Insurance Committee for its activity in our behalf, and that the rates as submitted be accepted and disseminated to our membership as soon as possible.

HOUSE OF DELEGATES ACTION—Adopted the report of the committee on professional liability insurance, with the additional recommendation that these rates be disseminated to MAG membership as soon as possible.

COUNCIL BUDGET, 1977-78 (O/C6F)

Robert E. Perry, M.D.

	Proposed Budget (when Different from Adopted Budget)	*Adopted Budget 6-1-77 to 5-31-78*
INCOME		
Dues Collection		$832,500.00
Interest and AMA Refund		24,000.00
Parking		4,800.00
Journal Advertising		35,000.00
Newsletter		3,000.00
Rental Income		37,500.00
TOTAL INCOME		$936,800.00
EXPENSES		
Communications		$ 78,617.00
Continuing Medical Education		55,771.00
Governmental Affairs		79,866.00
Journal		62,441.00
Legal Costs and Retainers		43,680.00
Legislation		70,352.00
Membership and Public Services	$196,927.00	194,927.00
Management Services, Business and Finance		49,024.00
Association Activities		83,497.00
Building Costs		140,695.00
TOTAL EXPENSE	$860,870.00	$858,870.00
Excess of Income over Expenses	75,930.00	77,930.00
		$936,800.00

	Adopted Budget 6-1-77 to 5-31-78
COMMUNICATIONS	
Personnel Salary	$ 21,814.00
Payroll Taxes	1,325.00
Insurance	813.00
Retirement Benefit	1,385.00
Telephone	13,000.00
Postage	25,800.00
Newsletter	4,200.00
Magnet Conference	4,000.00
Travel	1,680.00
Other Committee Costs	4,600.00
TOTAL COMMUNICATION EXPENSE	$ 78,617.00
CONTINUING MEDICAL EDUCATION	
Personnel	$ 33,255.00
Payroll Taxes	2,160.00
Insurance	1,305.00
Retirement Benefit	1,931.00
Scientific Assembly	12,400.00
Education Committee	2,200.00
Travel	2,520.00
TOTAL CONTINUING MEDICAL EDUCATION	$ 55,771.00
GOVERNMENTAL AFFAIRS	
Personnel	$ 39,833.00
Payroll Taxes	1,599.00
Insurance	1,042.00
Retirement Benefit	2,514.00
Research and Development	27,938.00
Travel	2,940.00
Liaison—Board of Human Resources	4,000.00
TOTAL GOVERNMENTAL AFFAIRS	$ 79,866.00
JOURNAL	
Personnel	$ 16,626.00
Payroll Taxes	1,103.00
Insurance	964.00
Retirement Benefit	298.00
Printing	38,850.00
Engraving and Cuts	1,900.00
Postage and Copyright	2,100.00
Mailing Labels	250.00
Clipping Service	350.00
TOTAL JOURNAL EXPENSE	$ 62,441.00
RETAINERS	
Legal	$ 35,000.00
Insurance Actuary	7,000.00
Other	1,680.00
TOTAL RETAINERS	$ 43,680.00
LEGISLATION	
Personnel	$ 49,931.00
Payroll Taxes	2,118.00
Insurance	1,387.00
Retirement Benefit	3,601.00
State Legislative Expense	4,315.00

	Proposed Budget (when Different from Adopted Budget)	*Adopted Budget 6-1-77 to 5-31-78*
National Legislative Expense		2,700.00
Travel		4,200.00
Legislative Bulletin		2,100.00
TOTAL LEGISLATION EXPENSE		$ 70,352.00
MEMBERSHIP AND PUBLIC SERVICE		
Personnel		$ 45,975.00
Payroll Taxes		2,498.00
Insurance		1,534.00
Retirement Benefit		3,591.00
WATS Line		4,500.00
Auxiliary—Health Careers		17,400.00
Roster		7,200.00
Travel—President		6,000.00
Travel—President-Elect		2,200.00
Travel—Past President		1,900.00
AMA Costs		
Caucus Breakfast		1,200.00
MAG Headquarters Suite		1,800.00
Southwestern Hospitality Suite		1,000.00
Travel—Delegates and Alternates		14,060.00
Travel—Officers		3,450.00
Interprofessional Council		125.00
AMSA to MAG Annual Session	$ 950.00	300.00
AMSA Travel Cost	—0—	650.00
State Medical Education Luncheon		225.00
AMA Leadership Conference (2 MD's)		850.00
Disabled Doctors Program	58,800.00	56,800.00
Access to Health Care		1,769.00
Health Planning		545.00
Awards		1,000.00
Professional Liability Insurance		1,983.00
Laboratory Quality		640.00
Liaison—Ga. State Med. Assn.		—
Maternal and Infant Welfare		1,100.00
Medical Aspect of Sports		500.00
Occupational Health		100.00
Peer Review		—
GaMPAC		3,000.00
Travel		3,360.00
MAG Foundation		3,600.00
Cost Accountability		900.00
Medical Practice		500.00
Joint Hospital Survey		2,672.00
Quackery		—
TOTAL MEMBERSHIP AND PUBLIC SERVICE	$196,927.00	$194,927.00
MANAGEMENT SERVICES, BUSINESS AND FINANCE		
Personnel		$ 19,882.00
Payroll Taxes		1,239.00
Insurance		1,604.00
Retirement Benefit		1,269.00
Dues and Subscriptions		1,650.00
Data Base Maintenance		6,000.00
Audit		3,600.00
Office Supplies		8,500.00
Travel		1,680.00
Sundry		200.00
Equipment Purchases		3,400.00
TOTAL MANAGEMENT SERVICES, BUSINESS AND FINANCE		$ 49,024.00

	Adopted Budget 6-1-77 to 5-31-78
ASSOCIATION ACTIVITIES	
Personnel	$ 39,637.00
Overtime	—
Council Contingent	10,000.00
Executive Committee Contingent	5,000.00
Executive Committee Discretionary	5,000.00
Payroll Taxes	2,318.00
Insurance	1,168.00
Retirement Benefits	2,449.00
Executive Committee Travel	3,300.00
Staff Travel	3,780.00
Meetings	2,000.00
Annual Session	8,845.00
Secretary	—
TOTAL ASSOCIATION ACTIVITIES	$ 83,497.00
BUILDING EXPENSE	
Personnel	$ 4,830.00
Payroll Taxes	244.00
Insurance	162.00
Retirement Benefits	387.00
Maintenance:	
Building	7,500.00
Equipment	2,800.00
Taxes—Assets	14,200.00
Janitorial Services	9,600.00
Utilities	20,000.00
Building Ins., Membership Ins.	5,508.00
Depreciation:	
Building	15,000.00
Equipment	4,300.00
Interest on Mortgage	30,370.00
Sinking Fund for Land Acquisition	46,250.00
Travel	480.00
Leasehold Improvements	6,664.00
Less Reimbursable Expense	(27,600.00)
TOTAL BUILDING EXPENSE	$140,695.00

REFERENCE COMMITTEE RECOMMENDATION

Mr. Speaker, your Committee notes the marked increase in the amount budgeted as legal retainers and feels that Council should make every effort to reduce this cost as soon as practical. Your Committee wishes to amend the budget by deleting $2,000.00 from the Disabled Doctors Program, making it read $56,800.00, and changing the total of the membership and Public Service Department to read $194,927.00. This department total is also to be changed to $194,927.00. The total expense is to be reduced from $860,870.00, and the excess of Income over Expenses be increased from $75,930.00 to $77,930.00. Also, Item AMSA to MAG Annual Session be amended from $950.00 to $300.00, and that AMSA Travel Cost be added and $650.00 be budgeted for this travel cost.

Mr. Speaker, your Committee recommends the Budget as amended be adopted.

HOUSE OF DELEGATES ACTION—Adopted the report of Council (Budget O/C6) as amended by the reference committee.

Chairman Blair expressed his appreciation to the mmbers of the reference committee for their time and effort, thanked others concerned for assistance rendered to the committee and thanked staff for help in the preparation of this report.

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

Certification Exam For Physician's Assistants

The National Commission on Certification of Physician's Assistants has scheduled the 1977 Certifying Examination for Assistants to the Primary Care Physician for October 5, 6, 7, and 8. The deadline for receipt of applications is July 6, 1977.

Formal training programs will receive an ample supply of applications for their students directly from NCCPA.

For eligibility information and/or individual applications, write:

Registrar, NCCPA
Suite 560, 3384 Peachtree Rd., NE
Atlanta, Ga. 30326
Telephone: (404) 261-1261

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard



REPORT OF REFERENCE COMMITTEE D

Lamar S. McGinnis Jr., M.D., Chairman

Chairman McGinnis reported that Reference Committee D met in the Walnut Room of the Macon Hilton Hotel on April 22, 1977, and carefully considered all the items of business referred to it.

The members of the committee present were: LaMar S. McGinnis Jr., M.D., Decatur, Chairman; Marvyn D. Cohen, M.D., Columbus, Vice Chairman; J. Moultrie Lee, M.D., Savannah; Jimpsey B. Johnson, M.D., Augusta; William C. Collins, M.D., Atlanta, and Jack F. Menendez, M.D., Macon.

RESOLUTION 17
EXPANSION OF FAMILY PRACTICE TRAINING

DeKalb Medical Society

WHEREAS, the stated policy of the Medical Association of Georgia is to support the training of more family physicians and other primary care physicians, and

WHEREAS, the vast majority of private practicing physicians, including those in specialties and subspecialties, see the need for more family physicians in all areas of the State of Georgia, and

WHEREAS, in academic medicine there is a varying degree of resistance to this principle since many of the full-time teaching faculty of necessity have narrowly limited their perspective, and

WHEREAS, input from practicing physicians has appreciably up-graded the quality of continuing medical education at the postgraduate level.

THEREFORE BE IT RESOLVED, that the Medical Association of Georgia actively support and encourage expansion of training in family practice at the student and resident level, and

BE IT FURTHER RESOLVED, that the Subcommittee on Medical Schools of the Medical Association of Georgia Education Committee become actively involved and meet regularly to assess the status of this aspect of the education of students and residents, and request the medical schools of the state to report to this committee the feasibility of adding family practice to their core curriculum.

REFERENCE COMMITTEE D

REFERENCE COMMITTEE RECOMMENDATION

Resolution 17, introduced by the DeKalb Medical Society, points out the need for more family physicians in all areas of the state and urges that the MAG support and encourage the expansion of training in family practice at the student and resident level. The Resolution further calls upon the MAG's Subcommittee on Medical Schools to assess this aspect of medical student and resident education and requests the medical schools to report to the Committee the feasibility of adding family practice to their core curricula. Reference Committee D received testimony that family practice education should begin early in the medical student's career. The Committee wishes to point out that the 1976 House of Delegates approved a recommendation in support of the training of family physicians. After consideration of the entire resolution, your Reference Committee recommends that the third "WHEREAS" clause, which speaks of the degree of resistance to family practice in academic medicine, should be deleted. Your Reference Committee recommends that the final part of the Resolution be amended to read, "BE IT FURTHER RESOLVED, that the Subcommittee on Medical Schools of the Medical Association of Georgia Education Committee become actively involved and meet regularly to assess the status of this aspect of the education of students and residents, and request the medical schools in the state to add family practice to their core curricula."

Mr. Speaker, your Reference Committee recommends adoption of this Resolution as amended.

HOUSE OF DELEGATES ACTION—Adopted Resolution 17 as amended by the reference committee.

COUNCIL

REQUEST FOR PROPOSAL FOR PSRO PLANNING CONTRACTS (O/C6E)

Robert E. Perry Jr., M.D.

In September (1976), the MAG Headquarters Office received a letter from the Department of Health, Education & Welfare on the subject of a new funding cycle for PSRO. This letter was referred to the January Council meeting for any consideration it wished to give the subject. Council elected to refer the letter to the House of Delegates.

On February 22, a more current letter superseding the letter of September 23, 1976, was received.

Consistent with the action of January Council, the following letter is referred to the 1977 House of Delegates for its consideration:

> Dear Mr. Moffett:
>
> The Bureau of Quality Assurance is committed toward full implementation of the Professional Standards Review Organization (PSRO) program as rapidly as PSROs become qualified. Toward this objective we will be attempting in fiscal year

1977 to fund physician organizations as planning PSROs in all PSRO areas not presently represented by a PSRO organization. The purpose of this letter is to inform you of the status of our plans for a new PSRO funding cycle.

Shortly, the Health Services Administration will announce the release of a Request for Proposal (RFP) which will solicit proposals for PSRO planning contracts, the purpose of which will be to develop the formal plan necessary to qualify as a conditionally designated PSRO. Multiple awards will be made under this competitive procurement, but only one organization per PSRO area will ultimately be designated.

The RFP will be sent to interested organizations in February and the anticipated due date for contract proposals will be in April. Each proposal will be evaluated on the basis of four general criteria: organization composition and structure, problem and approach, personnel, and facilities. Competition and awards will be made on a DHEW regional basis. The best proposals will have priority in funding, though all acceptable proposals will be funded if funds are available.

Organizations meeting all of the following conditions will be eligible to submit a proposal under the RFP:

1. A professional physician association whose membership is open to all doctors of medicine and osteopathy licensed to engage in the practice of medicine and/or surgery and currently performing professional activities in the PSRO area.

2. An organization legally incorporated as a non-profit organization at a date prior to the date(s) scheduled for contract award(s), and

3. An organization having a membership composed of a substantial proportion of the physicians (M.D.s and D.O.s) in the PSRO area or demonstrating the potential to obtain this membership level before conditional designation as a PSRO.

Your organization has been identified as being potentially eligible to be designated as a planning PSRO. We therefore have requested the Health Services Administration (HSA) to send you a copy of the Request for Proposal (RFP) when it is issued in February. You will not need to separately request an RFP from HSA, though you should advise the appropriate Regional Office of any change of address (see enclosed list).

Since we do not expect to be able to directly fund new organizations as conditional PSROs in fiscal year 1977, we urge all interested physician organizations to apply as planning PSROs under this forthcoming solicitation. By law, until January 1, 1978, only physician organizations are eligible for consideration as PSROs, except in certain instances defined by statute.

In establishing the time limit of January 1, 1978, congressional intent was clearly that at some point in time the need to complete implementation of the PSRO program would take priority over the desirability of having only physician organizations designated as PSROs. Accordingly, the Department is now in the process of developing Federal regulations to define "alternative" PSROs, in the sense of alternatives for the physician organizations which have to date been solely eligible for PSRO designation. These regulations, once final, will permit the Secretary of Health, Education, and Welfare, after January 1, 1978, to begin consideration of alternative PSROs for those areas regarding which no physician organization has expressed interest in PSRO designation.

We urge you to alert your organization's governing body members and other active members of the anticipated schedule for the new planning PSRO contract cycle in order to ensure adequate consideration of the submission of a proposal.

Sincerely Yours,
MICHAEL J. GORAN, M.D.
Director, Department of HEW

RESOLUTION 27
PSRO PLANNING CONTRACTS

Bibb County Medical Society

WHEREAS, PSRO is an objectionable law for both the public and the medical profession; and

WHEREAS, PSRO will not and cannot insure quality medical care but will, in effect, ration same, and

WHEREAS, PSRO will interfere with the physician's free exercise of his best clinical judgment, and

WHEREAS, this law will fail to achieve its stated purpose if implemented; and

WHEREAS, it would show lack of informed judgment to presume that cooperation with the Federal Government will benefit this body in any way; and

WHEREAS, if the medical profession forms a PSRO organization, the medical profession itself will bear the blame for the failure of such organization—and fail it will—,

THEREFORE, BE IT RESOLVED that neither the MAG, Georgia Medical Care Foundation, nor any other MAG sponsored organization apply for a planning contract or take any part in implementing this objectionable law.

REFERENCE COMMITTEE RECOMMENDATION

The reference committee next considered together two items relating to PSRO—a request from Council to consider recent letters received from the HEW on the subject of application for a planning contract for PSRO, and a Resolution from the Bibb County Medical Society recommending that MAG not apply for a PSRO planning contract.

The committee heard considerable testimony on the subject, including that of the Director of the Division of Quality and Standards, U.S. Public Health Service, HEW (Southeast Region), and the Medical Director of the Georgia Medical Care Foundation. Your reference committee wishes to remind the House that at its 1975 meeting it established a policy on the application for a PSRO planning contract. The reference committee finds convincing the argument that PSRO remains a law of the land; that after January 1, 1978, non-physician groups may apply for the contract; that the Georgia Medical Care Foundation—the MAG affiliate for peer review—should be able to meet the requirements

for a PSRO; and that if this task must be done, it is best done by a physician-controlled group with a good track record in peer review. Your reference committee therefore recommends that the Resolution from Bibb County Medical Society be not adopted.

Furthermore, your committee wishes to point out that the Georgia Medical Care Foundation is already performing the peer review function which would be undertaken by a PSRO (with the exception of concurrent review) and* recommends *that the MAG should apply for a PSRO planning contract 15 days before the January 1, 1978 deadline for priority consideration to physician groups. In view of testimony received, we* recommend further *that the Georgia Medical Care Foundation be the applicant. If this is subsequently found not to be legally sound, then we* recommend *that PSROG be the applicant.

HOUSE OF DELEGATES ACTION—Voted to not adopt Resolution 27-77. The House further voted to amend the recommendation of the reference committee by deleting January 1, 1978, as the arbitrary date on which a PSRO Planning Contract application would be filed, and by adding the provision that the application be immediately withdrawn if the deadline for such application is extended after the application has been made. The amendment also provides for the MAG Board of Directors, in consultation with legal counsel, to determine who the appropriate applicant for PSRO in Georgia should be. As amended, the reference committee report would read as follows: "Furthermore, your committee wishes to point out that the Georgia Medical Care Foundation is already performing the peer review function which would be undertaken by a PSRO (with the exception of concurrent review) and recommends that the MAG should apply for a PSRO Planning Contract 15 days before the deadline for priority consideration to physician groups. If the deadline is extended after the application is made, the application should be immediately withdrawn. In view of the testimony received, we further recommend that the Council, now the duly constituted Board of Directors of the Medical Association of Georgia, in consultation with MAG legal counsel, explore the legal requirements of the Board and the Membership for PSRO and decide at the September 1977 meeting as to the proper applicant, be it the MAG, GMCF or PSROG." (Note: Lines of the original reference committee report which are in italic, were deleted.)

COMMITTEE ON SCIENTIFIC ASSEMBLY (C1)

Carter Smith Jr., M.D.

Following an evaluation of the 1975 MAG Scientific Assembly, MAG's 1976 House of Delegates elected to continue this educational activity on an annual basis, subject to review. The 1976 Scientific Assembly was held on November 19-20 at the Omni International Hotel in Atlanta and MAG owes a debt of gratitude to Dr. James Van Buren for serving as Chairman of a very successful meeting.

FORMAT

This year's Assembly was again primarily a forum for the state specialty societies to put on their own scientific programs. MAG furnished the meeting space,

REFERENCE COMMITTEE D



Members of Reference Committee D

audiovisual equipment, publicity, printing, and educational funds for speakers. Fifteen specialty societies participated, with programs ranging from two hours to two half-days.

In addition to the scientific programs, the MAG sponsored a luncheon and an educational program for spouses. The luncheon featured the Calhoun Lecture, delivered by the President of the American College of Physicians, Dr. Jack D. Myers, on the subject of graduate training opportunities in medicine. The spouses' program featured two speakers on art and furniture in the home. There were also some ten educational exhibits, although no commercial exhibits were allowed.

ATTENDANCE

Five hundred and twenty-eight people registered for the Assembly, up 125 from the previous year. Of the total number, 386 paid registration fees, 80 were speakers, and 51 were interns, residents, or guests. The number of registered attendees at individual scientific programs ranged from 12 (Public Health) to 134 (Internal Medicine). Of the physicians paying registration fees, 353 are MAG members and 165 are from outside of the Atlanta area (with 6 from out of state).

FINANCING

The amount budgeted for the Assembly was $13,343.00. Actual expenditures were $14,398.00. Since gross receipts (including registration fees and contributions from pharmaceutical firms) totalled $9,109.00, the cost of the meeting to the MAG was $5,289.00, over $1,000.00 less than the previous year. Included in expenditures was $8,255.00 for the educational programs of the various specialty societies. The committee regards these "speakers' funds" as essential to both the participation of the specialty groups and the quality of the education. This year there were 18 out-of-state speakers and numerous speakers from within the state.

FUTURE PLANS

The committee has set the dates of November 18-19 for the 1977 Scientific Assembly, with the site again to be the Omni International Hotel. The 1977 Planning Committee Chairman is Carter Smith Jr., M.D.

AREAS OF CONSIDERATION

The committee believes that the 1976 Scientific Assembly was a most successful educational venture and that it represented a significant improvement over the fine 1975 Assembly. We are now beginning to establish a tradition of high-quality continuing medical edu-

cation, and this November we were surveyed for accreditation of our programs by a team of physicians from the AMA.

Although most programs enjoyed good attendance at the 1976 Assembly, the poor attendance at the excellent spouses' program suggests to the committee that this activity should be discontinued. Attendance at the MAG luncheon was down by about a third this year, and the committee will try to arrange scheduling and publicity to secure better attendance in 1977. The programs in Public Health and Psychiatry had sparse attendance, and the committee will attempt to work out the problems with these specialty groups. The absence of programs in Family Practice, Obstetrics-Gynecology and Pediatrics was keenly felt, and noted by the AMA surveyors, but the committee does not foresee any immediate change in this situation.

Several medical organizations not represented on MAG Interspecialty Council asked to sponsor programs at the 1976 Assembly, and the committee's response was made difficult by the absence of written guidelines for this eventuality.

RECOMMENDATION

The MAG should continue on an ongoing basis to review the accomplishments and value to the membership of the annual Scientific Assembly.

REFERENCE COMMITTEE RECOMMENDATION —The report of the Committee on Scientific Assembly evaluates the 1976 Scientific Assembly and contains the recommendation that the MAG continue to review the value of the membership of the Annual Scientific Assembly. Your Reference Committee agrees with the recommendation contained in the report. However, after deliberation it wishes to add to that recommendation the further recommendation that the Committee on Scientific Assembly conduct, in conjunction with the Education Committee, a survey of the MAG membership on the value of the Scientific Assembly, its continuance, and alternative approaches for MAG to support continuing medical education.

Mr. Chairman, your Reference Committee recommends adoption of the report's recommendation as amended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Scientific Assembly as amended by the Reference Committee.

JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA (D4)

Edgar Woody Jr., M.D., Editor

CONTENT

During the 1976-77 year, we have continued our efforts to tailor the *Journal* content to the current needs of our readers. We have accordingly devoted several issues of the *Journal* to specific topics which we felt were of urgent concern to the physicians in Georgia.

The June issue, traditionally, presented the Annual Session proceedings and annual reports; July explored some history, telling our readers about some Georgia physicians who played significant roles in our country's history; in September the business and management side of medical practice was discussed; the Scientific Assembly program was given in detail in the October issue; March gave a progress report on HSA's in Georgia.

CREDITS

Much appreciation is due our helpful Contributing Editors for their continuing helpful functions in soliciting and reviewing scientific papers for publications. Our Publications Committee, which is actually the Executive Committee of Council, has always been responsible and helpful in matters of editorial policy for the *Journal*. Our Heart and Cancer pages have maintained their high level of quality under the guidance of the Georgia Heart Association and the Georgia Chapter of the American Cancer Society.

J. Winston Huff and Richard Vincent, our MAG legal counsel, has continued to produce superior and timely legal pages on a monthly basis.

Dr. J. G. McDaniel, with his entertaining feature page "I've told this before . . . ," has received wide acclaim for his contributions.

Bob Hamill, our cover artist, has produced some outstanding designs in the last year.

Final mention should be made of the fine contributions and helpful advice given by members of the Headquarters Office staff through the year. Without their input, we could not function.

PERSONNEL

During the past year, we reluctantly accepted the resignation of Miss Kathy Morse, our Managing Editor for the past several years. She was outstanding in the performance of her duties and will be missed by all of us. We wish her well in her new position with Fulton County.

We have been most fortunate to obtain as our new Managing Editor, Mrs. Sharon Smith, a native of Alabama and a Journalism graduate of Georgia State University. With her active background of writing and editing, we are expecting great things from our new Managing Editor.

LOCAL ADVERTISING

A new effort is underway to stimulate statewide advertising in the *Journal*. It is felt that this area holds promise for a significant increase in *Journal* revenues. Negotiations are now underway to obtain the services of an advertising representative who might be able to help us.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

At a recent meeting held in Chicago in January, it was announced that a new sales force has been engaged for the solicitation of national pharmaceutical advertising. Guarded optimism was expressed by the new sales force for a 10% increase in advertising revenues for the coming year. This would represent a reversal of a continuing trend over the past three years. It is hoped that their estimates are accurate.

REFERENCE COMMITTEE RECOMMENDATION —The Annual Report of the Editor of the Journal of the Medical Association of Georgia was received for

information. Your Reference Committee recommends that the report be filed with special commendation for the fine work of the Editor.

HOUSE OF DELEGATES ACTION—MAG Journal report filed with special commendation for the fine work of the editor.

RESOLUTION 22
HEALTH EDUCATION IN SCHOOLS

Medical Association of Atlanta

WHEREAS, many diseases, injuries, and deaths in Georgia and the United States are directly related to bad personal habits such as excessive alcohol, tobacco, and food; excessive automobile speeds; a lack of exercise and rest; poor diets; and general ignorance of good health habits, and

WHEREAS, there is well-documented evidence for a deficiency of knowledge of good health habits, human biology, and normal physiology in students graduating from public schools in Georgia, and

WHEREAS, a few school systems in Georgia have even the minimum health education as required by law,

THEREFORE, BE IT RESOLVED that the Medical Association of Georgia urge the State Board of Education to actively promote health education programs in individual school systems, and

BE IT RESOLVED FURTHER that the Medical Association of Georgia assist whenever possible the colleges and universities in Georgia who now offer degrees in health education, and

BE IT RESOLVED FURTHER that the Medical Association of Georgia join with its Auxiliary, The Department of Human Resources, the State Parent Teacher Association, and others in making this deplorable lack of health education in our schools known to the citizens of the state of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 22, introduced by the Medical Association of Atlanta, points out that few school systems in Georgia have adequate health education and urges the MAG to assist the State Board of Education in actively promoting health education programs in the schools; assist the colleges and universities with their degree programs in health education; and join with the Auxiliary to the MAG, the Department of Human Resources, the State PTA, and others in making known the need for improved health education in the schools.

Mr. Speaker, your Reference Committee heard no testimony in opposition to the resolution and recommends that it be adopted.

HOUSE OF DELEGATES ACTION—Adopted Resolution 22.

RESOLUTION 23
COUNTY MEDICAL SOCIETY PROJECT IN HEALTH EDUCATION

Medical Association of Atlanta

WHEREAS, organized medicine should take the lead in promoting health among our citizens, and

WHEREAS, the public is very concerned about matters related to health and disease and looks to physicians for leadership but will turn to other sources if necessary, and

WHEREAS, local school systems are becoming increasingly interested in health education for students but often lack knowledge of the methods of developing programs and establishing priorities, and

WHEREAS, health forums, seminars, and health panels have proved to be very popular among our citizens and help educate them about the hazards of drugs, quackery, optometry, podiatry, and other less than complete healing arts, and

WHEREAS, health education is an excellent way for organized medicine to gain public recognition for service to the community,

THEREFORE, BE IT RESOLVED that the Medical Association of Georgia encourage each county medical society to establish a committee on health education to assist school systems in developing comprehensive health curricula, to assist voluntary health agencies in public and patient education, and to consider the promotion of health forums, media presentations, and other means of disseminating health information to the public.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 23, introduced by the Medical Association of Atlanta, points out the public concern for matters related to health and the leadership role that physicians can play in educating the public about health. It calls upon the MAG to encourage each county medical society to establish a committee on health education to assist school systems in developing comprehensive health curricula, to assist voluntary health agencies in patient education, and to consider the promotion of health forums, media presentations, and other means of disseminating health information to the public.

Mr. Speaker, your Reference Committee heard no testimony in opposition to the resolution and recommends adoption.

HOUSE OF DELEGATES ACTION—Adopted Resolution 23.

REFERENCE COMMITTEE D

COUNCIL
ACCOUNTING FOR CME (O/C6J)

Robert E. Perry, M.D.

Council has reviewed the following resolution and recommends that it be forwarded to the AMA for introduction at the 1977 House of Delegates in San Francisco.

WHEREAS, continuing medical education as a formal postgraduate training mechanism for physicians is a realistic means of keeping up with current developments in medicine, and

WHEREAS, many physicians in this country avail themselves of these educational opportunities, and

WHEREAS, many organizations, including the AMA, Specialty Societies and in some cases State Boards of Medical Examiners, require documentation of such efforts, and

WHEREAS, the compilation and verification of such

records is often a very difficult and time-consuming process, and

WHEREAS, the AMA has begun to investigate the feasibility of becoming the central repository for such data, now therefore

BE IT RESOLVED that the AMA proceed with its study of the feasibility and cost of providing a "credit card" type accounting system of continuing medical education activities, making it available to AMA members as well as to non-members, for a yearly fee to cover the expense of the process, and

BE IT FURTHER RESOLVED that if this feasibility study proves favorable, the AMA implement such a system.

REFERENCE COMMITTEE RECOMMENDATION —This resolution from Council speaks of the need for a formal mechanism for recording attendance by physicians at CME activities and urges the AMA to proceed with its study of the feasibility and cost of providing such a system, for AMA members as well as non-members; it recommends further that the system be implemented if it is found to be feasible.

Reference Committee heard testimony to the effect that attendance at CME programs is no assurance of the quality of the physician's ability. Since there is danger that the national system of accounting for CME might be used in an attempt to assess physician quality, an accounting system for CME hours on a national level would seem to be a step in the wrong direction.

Mr. Speaker, your Reference Committee recommends that this resolution be not adopted, since recording of attendance of CME activities can be better taken care of by the specialty societies and at the local and state levels.

HOUSE OF DELEGATES ACTION—Voted to not adopt Council Report O/C6J.

LABORATORY QUALITY (C20)

Richard E. Dubois, M.D.

One of the first activities undertaken by the Committee on Laboratory Quality during the past year was to modify and increase its membership by giving representation to the specialities performing a large number of laboratory tests.

The "Statewide Survey of Office Laboratory Practices Among Membership of the Medical Association of Georgia" and data resulting from the survey conducted in cooperation with the Georgia Department of Human Resources was reviewed by the Committee early in the year. At this time physicians from the Center for Disease Control informed the Committee that no other state has data on laboratory work performed by physicians in private offices and they suggested that federal funds might be available to conduct a feasibility study for a workable system to assure quality of laboratory work in office practices.

The committee developed a proposal which has been submitted to the Bureau of Quality Assurance, HEW, and other potentially interested funding agencies. In the program described, a stratified sample of physicians representative of practice in Georgia would participate in a proficiency testing program sponsored either by the American Society of Internal Medicine or the College of American Pathology. As they analyze data resulting from the proficiency testing programs, the Committee would identify potential problem areas and identify the educational followup most effective in correcting or improving the situation. The educational component, which is the most important element of the program, would include a periodic newsletter, letters from the Committee, and educational programs.

The committee on Laboratory Quality feels a strong commitment to assuring quality of laboratory work in physicians' offices through use of proficiency testing and educational feedback. Since the project has not yet been funded, the committee has established February 1 as a target date at which time they would begin to actively develop an alternative program toward achieving their objectives in laboratory quality. Such a program would include the following components:

1. Voluntary participation by Georgia physicians. Two or three mailings from MAG, and perhaps the specialty societies involved, will be made in the fall to enroll those physicians performing laboratory work in their offices.

2. Educational information provided to physician. This would be accomplished by:

   a) Exhibits at meetings of the annual session, scientific session, and speciality societies stressing the value of quality control and proficiency testing.

   b) Announcing programs sponsored by other organizations and scientific products companies in the *MAG Newsletter* and through mailings. Physicians will be encouraged to send their laboratory personnel to these educational sessions as well as attending the meetings themselves.

3. A labmobile travelling over the state. This fully stocked lab would be driven throughout the state by a "part-time" person who would be available to answer questions and demonstrate laboratory equipment and the use of quality control measures. Funds for this activity would come from interested persons, laboratory equipment suppliers, or educational foundations.

When Congress recessed, the Clinical Laboratory Improvement Act had passed the House of Representatives and was awaiting the vote of the Senate. It appears that federal legislation mandating controls over laboratory procedures will indeed soon become a reality. It is the belief of the Committee on Laboratory Quality that a physician should be encouraged to voluntarily enroll in a proficiency testing program so that he will be able to assess the performance of laboratory procedures in his office, and thus evaluate the quality of his laboratory before he is confronted with the federal government's mass of bureaucratic requirements. Therefore, the Committee submits the following recommendations:

RECOMMENDATIONS

1. That the House of Delegates approve this activity and lend its support in implementing the program and in encouraging physician participation.

2. That the House of Delegates direct the Committee to continue development of programs with educational feedback and seek funding from a variety of sources and continue to develop an alternative program in the event funding from a single source is not available.

REFERENCE COMMITTEE RECOMMENDATION —The Annual Report of the Committee on Laboratory

Quality describes a project in which physicians in Georgia would participate in a proficiency testing program for laboratory quality, sponsored by the American Society of Internal Medicine or the College of American Pathology. Elements of the program would include mailings to MAG members, educational information through exhibits and newsletters, and a labmobile travelling over the State to demonstrate laboratory equipment and the use of quality control measures.

The report contains the recommendation that the House of Delegates approve this activity and lend its support in implementing the program and in encouraging physician participation. The report further recommends that the House direct the committee to continue development of programs with educational feedback and seek funding from a variety of sources and continue to develop an alternative program in the event funding from a single source is not available. Testimony brought before the reference committee focused on whether the funding for the activities in laboratory quality would come from government contracts, which would not be in keeping with current MAG policy. It was determined that funding would be sought from sources other than the government, such as private foundations and scientific companies.

Mr. Speaker, your Reference Committee believes the program to be a good one and therefore recommends adoption of the report and its recommendations.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Laboratory Quality.

COUNCIL
CLINICAL LABORATORIES (O/C6C)

Robert E. Perry, M.D.

In recent months, the image of medicine has been tarnished by charges of fraud and abuse in the use of clinical laboratories. Kickbacks, misrepresentation, overpayment, and lying by a small number of laboratories and physicians have received wide public notice and stimulated draconian regulatory proposals.

Although Medicare does not permit physicians to charge more than a nominal handling fee for work done by independent laboratories, most physicians' statements include a markup fee not separately itemized, some of them quite high. Examples of this have been seen in review of Foundation claims or by cases cited by reputable clinicians. The GAO has investigated these practices in Georgia; and physicians in San Diego are under indictment for them.

Charges beyond those of the laboratory to cover costs for obtaining and handling specimens, bad debts, and billing costs are necessary and of economic necessity. It is not these, but the inappropriate charges which should be under scrutiny.

The large corporate-owned laboratory chains are advocating state laws forbidding clinicians to bill patients for assays, requiring, instead, that laboratories bill the patients directly. It is considered quite likely that a similar bill will be brought before the Georgia legislature in the next two to three years.

An alternative approach might be for the Medical Association of Georgia to sponsor a so-called "disclosure" law which would require only that a physicians' statement itemize separately the charges of his reference laboratory. With computerized billing, this should not be a heavy burden and would give the clinician the option of whether he or his patients should be billed by a laboratory.

REFERENCE COMMITTEE D

The following stand taken by the AMA in a resolution adopted at the 1969 House of Delegates has been reiterated in the AMA Judicial Council Opinions and Reports and an "AMA News" editorial (July 5/12, 1976):

1. It is preferable that the laboratory, not the attending physician, bill and collect from the patient or third party payor for laboratory services. Where circumstances make this impractical or where increased costs to the patient would result, the bill submitted by the attending physician to his patient or third party payor should state the name of the laboratory performing the services for his patient and the exact amount of the charge paid or to be paid by the physician to the laboratory. Medical societies are urged to use all means legally available to them in effectuating the foregoing.

2. The attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission, or profit on the services rendered by a laboratory is exploitation of the patient.

This problem was brought before the Council at its January 9 meeting by Frank Matthews, M.D., representing the Georgia Association of Pathologists. Because of its pervasive nature, Council voted to refer this matter to the House of Delegates, therefore,

The question before the House is to consider the desirability of sponsoring legislation for a disclosure law requiring a physician to itemize separately the charges of his reference laboratory.

REFERENCE COMMITTEE RECOMMENDATION —Report O/C:6C from Council calls upon the House to consider the desirability of sponsoring legislation for a disclosure law requiring a physician to itemize separately the charges of his reference laboratory. This is in response to current items in the media about kickbacks, overpayment, and lying by laboratories and physicians relating to the fee charges for laboratory work.

Although some testimony brought before the reference committee was in favor of supporting a disclosure law, other testimony emphasized that it would be very hard to justify to the patient any fee for the interpretation and evaluation of laboratory work. Since a disclosure law would create too many practical problems for physicians, your reference committee wishes to make no recommendation about support of such legislation. However, since the problem alluded to in the report is a real one, your reference committee recommends that MAG go on record as deploring any *exorbitant* fees for laboratory services not justified by cost and service rendered.

HOUSE OF DELEGATES ACTION—The House voted to adopt the recommendation of the Reference Committee on this report but added one floor amendment, that being to delete the word "exorbitant" as it appears in the last sentence of the recommendation of the Reference Committee.

COMMITTEE ON COST ACCOUNTABILITY (C8)

Harrison L. Rogers, M.D.

In considering the ways in which the cost of health care might be controlled, the Cost Accountability Committee considered four major areas which influence the cost of health services.

1. Physicians must look at the cost of health care. They must be aware of the cost of the services ordered. This would include checking into the necessity for continued testing and coordination between physicians on tests ordered for a patient and between the physician's office and the hospital so there is no duplication. Medical schools should emphasize somewhere in their curriculum the cost of medical care. It should be recognized that physicians in training order greater numbers of tests and procedures, so their orders particularly should be monitored.

2. In many cases, hospital facilities are inappropriate and inefficient to perform certain procedures. Such procedures might be better done in a less costly setting such as the physician's office or in the outpatient department rather than on an inpatient basis. The hospital should carefully evaluate bills sent to insurers and to patients to be certain that the patient had actually received the services they had been billed for. The hospital ought to provide some mechanism for periodically informing the physicians of the charges being made for procedures provided to their patients.

3. The health insurance industry has taken a relatively responsible position in controlling the cost of health care. They advise their subscribers of how to keep health care costs down. In addition to this, however, the insurers ought to emphasize their outpatient coverage so that the individual will get as much of his services provided there as possible, as opposed to on an inpatient basis. Labor and management should make an effort in the use of deductibles or of co-insurance as a method for controlling utilization. The health insurer can assist the physician in controlling utilization by advising labor and management of the magnitude of the problem, when the physician is faced by an overdemanding patient or family.

4. In the long run, it is only the public who can have a long term effect on the cost of health care. Only if they drive with greater care, eat better, quit smoking, restrict alcohol intake, and agree with strict policies for use of services and facilities will utilization of health services decrease.

CONTROLLING HOSPITAL COSTS

The major impact to be made in the area of cost containment must be in the hospitals. This can only be done at the local level through the efforts of individual physicians, hospital personnel and patients. The committee agreed that it could not do much directly to reduce cost. This committee could be useful in preparing responses to medicine's critics. Also, it could develop informational items for newspapers, radio, TV and a general public relations approach to emphasize the concern of providers in reducing costs.

It is obvious that both management and labor have become more and more concerned with rising health care costs. Representatives of these groups could become involved with providers in an effort to look at this problem. It was suggested that on a regional or local basis, the county medical society and other provider representatives get together with labor, management and the media to look into rising health care costs in their areas and determine what should be done in order to reduce rising costs or to moderate the increases occurring.

It was suggested that out-patient benefits with low deductible attached, while high deductible and co-payment for in-patient care was included, might be a method for stimulating the use of lower cost care by patients. Representatives of the Blues pointed out that this was an extremely complex field and that any effort made in an area such as this had to be analyzed thoroughly because it was possible that another aspect of the health care delivery system would be adversely affected. The Committee believed that there should be an effort made to eliminate the first dollar coverage under health insurance plans. Also, deductibles and co-insurance should be encouraged, not only for private coverage but also for Federal programs like Medicaid and Medicare.

Another area in which the hospitals could reduce costs is in efforts with patients' self care. This would include expansion of ambulatory care units in the hospital. There should be renewed emphasis placed on the use of cafeterias, self-medication by the patient, and a general effort to have the patient take care of himself while hospitalized.

Utilization review should receive greater emphasis in the hospital and be better coordinated so that problem diagnoses, physicians and patients, could be more easily identified and reviewed. The committee felt that an upgrading of all medical audits should be undertaken in the hospital and that utilization review should cover 100% of the patients. There was general agreement that hospital controls are much better than control efforts made by insurance companies or government. The insurance company or government can sometimes be used as an "excuse" by the physician in order to explain to the patient that certain services cannot be covered. It was suggested that insurers consider elimination of such items as private room coverage, private duty nursing, etc., unless alternative services such as intensive care units are not available in the hospital.

Government interference in medical practice through a requirement that certain tests to be performed was brought up as another example of added costs. It was suggested that tests for admission to hospitals, extended care of nursing homes be examined to be sure that duplicate testing was not being done and considering whether or not certain tests were at all needed prior to or at admission.

Review of technical advances was felt to be necessary in order to control rising costs. A physician ought to look at his practice and the type of patients he has, to determine whether he really needs expensive procedures performed by new technologically sophisticated equipment. He should determine whether the test results he obtains from this equipment will make any difference in his diagnosis or treatment of patients. It was also pointed out that procedures such as kidney dialysis both on an in-patient and home basis, ought to be looked at from the point of view of the quality of life available to the individuals undergoing this procedure. Certainly there is a significant cost differential between

in-patient and home treatment which also ought to be examined. It was suggested that possibly the Medical Care Foundations could become involved in developing guidelines for new technologies such as CAT scanners.

Out-patient surgical services seem to be an area which can help reduce medical care costs. Ambulatory surgical centers are not generally available in Georgia and are not licensed. There were some questions raised whether or not licensure was the appropriate way of dealing with the accreditation of, or making a determination of the quality of services provided in these facilities. It was suggested that the individual third party payors might establish some sort of agreement with the ambulatory surgical centers rather than providing licensure for the facilities.

The Committee reviewed the possible ways in which local accountability committees could help their hospitals reduce costs. It was suggested that the hospitals post the charges for the 20 most common procedures so that the physician could easily see what the cost of services was. It was also thought that by listing the cost of services on the patient's chart for a period of time, the physician might become more conscious of what his patients were being billed. Sending a copy of the hospital bill to the physician from the hospital might be another way of alerting the doctor to the cost of care. Simply maintaining a listing of tests, lab procedures, x-rays, and keeping their costs posted would be a method of informing staff members who order these tests as to what they are really doing in terms of adding to the bill of the patients. This could be done on a departmental basis in larger facilities and an overall hospital basis in smaller facilities. The Committee strongly supported the concept of the hospital staff looking into the endorsement of pre-admission testing.

Another area which may be a very significant impact on health care is the HSA. The Committee felt that physicians should be strongly encouraged to participate in the activities of the HSA's in their area.

RECOMMENDATIONS

In conclusion, the Committee suggested that the following should be made as recommendations to the MAG House of Delegates as part of this Committee's report:

1. Support the establishment of regional councils on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals and the media. These councils are to serve as a continuing forum for education of both the public and providers.

2. Urge insurance companies to eliminate first dollar coverage and to institute the use of deductible and co-insurance. Out-patient benefits should be expanded with consideration given to higher deductible and co-payment for in-patient care. The concept of co-insurance and deductible should be extended to Medicaid and Medicare.

3. Endorse expansion of utilization review methods to cover 100% of hospital patients. Medical audit procedures should be upgraded with assurance that findings are brought to the attention of the medical staff for their consideration of changing hospital procedures as indicated.

4. Support restrictions on costly additional services such as private room and private nurse services by insurance carriers. Elimination of duplicate testing for admission to the hospital, extended care or nursing home facilities should be strongly encouraged rather than required, as is often the case in government programs.

5. Hospitals should be urged to consider introducing or expanding self-care by the patient, including self-medication, room care, and use of cafeteria facilities.

6. Hospital medical staffs should be encouraged to inform themselves about costs of medical care in their facilities. This might include:

a) Posting the charges for the 20 most common procedures performed in the hospital so that physicians will see the prices in a prominently placed display.

b) On a periodic basis listing on his chart the cost of services provided to the patient.

c) Sending a copy of the hospital bill to the patient's physician by the billing office.

d) Keeping the medical staff members informed on hospital costs such as lab procedures, x-rays, tests, etc.

e) Establishing a "Cost Control" Committee of the medical staff or assign this to an existing committee.

7. Encourage local physician involvement in health systems agency activities through membership on task forces, committees and boards of directors, to assure that the best interests of patients are considered in all HSA decisions.

8. Request assistance from our Medical Schools in presenting this problem of health care costs to their students.

REFERENCE COMMITTEE D

REFERENCE COMMITTEE RECOMMENDATION —The Report of the Committee on Cost Accountability addresses the increasingly important problem of the soaring cost of health services and suggests a number of ways in which costs could be controlled. All testimony received was in agreement that the problem is a serious one and that the MAG should take the initiative in trying to do something about it. There was some disagreement about whether the committee had actually fulfilled its charge of addressing the issue of cost accountability rather than the related issue of cost containment.

Recommendation 1 calls for the MAG to support the establishment of regional councils on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals, and the media. These councils would serve as a continuing forum for education for both the public and providers. The reference committee wishes to point out that the wording of this recommendation might imply that the regional councils would in fact be the Health Systems Agencies newly established by the Health Planning Act. Since this is not the intention of the author of the report, your reference committee recommends adoption of the recommendation as amended to read as follows: "Support the establishment of community meetings on health care costs to be composed of representatives from labor, management, local county medical socie-

ties, hospitals, the media, and consumer interest groups."

Mr. Speaker, your reference committee recommends adoption of Recommendation 1 as amended.

Recommendations 2-8 call for a number of measures with which reference committee is in agreement. Your reference committee observes that the entire report is largely consumer-oriented and wishes therefore to add a ninth recommendation, that the Committee on Cost Accountability continue to study the issue of cost accountability with particular reference to ways in which expenditures for health services can be influenced by (1) high deductible insurance, (2) making sure that the patient receives the services he pays for, (3) maintaining restraint on the rise in physician fees, (4) continuing to upgrade the quality of care, and (5) denying loudly the concept that medical care is a public utility.

Mr. Speaker, your reference committee recommends adoption of the report with recommendations as amended.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Cost Accountability with the following amendment to recommendation 1 to read: "Support the establishment of community meetings on health care costs to be composed of representatives from labor, management, local county medical societies, hospitals, the media and consumer interest groups, to be selected by the county medical societies."

Adopted the recommendations of the report 2 through 8 with the following change: The first sentence of recommendation 3 of the original report, "Endorse expansion of utilization review methods to cover 100% of hospital patients," was deleted. The additional recommendation (number 9) made by the reference committee was amended by Delegate F. William Dowda to delete Part 3 thereof and by renumbering Part 4 as Part 3 and Part 5 as Part 4. This was adopted.

COMMITTEE ON THE MEDICAL ASPECTS OF SPORTS (C28)

Fred L. Allman Jr., M.D.

PURPOSE OF COMMITTEE

The purpose of the Committee on the Medical Aspects of Sports of the Medical Association of Georgia is to help make member physicians more knowledgeable concerning the health needs of the athlete. These needs include information concerning prevention, recognition, treatment, and the rehabilitation of injuries and illnesses that are associated with both organized and recreational sports participation. The committee also serves as liaison to help promote a close mutually beneficial relationship between the medical profession and coaches, school administrators, athletes, and parents.

PROJECTS OF THE COMMITTEE

As in past years, this committee sponsored a program in conjunction with the Georgia High School Coaches Association Clinic and outstanding speakers to the Clinic included Dick Butkus and Dr. Doug Brown. Also as in past years, Mrs. Mary Helen Goodloe was responsible for the nutrition luncheon which is funded each year by Coca-Cola. This has become a very important part of the one-day meeting.

CERTIFICATION OF COACHES

The committee continues to encourage school administrators and the Georgia High School Coaches Association to implement the certification of coaches as has been done in several other states. The committee feels that this is a very necessary action to be taken as soon as feasibly possible.

NEWS RELEASE FOR HEAT PRECAUTIONS

Each August the committee sends to the various news media throughout the state precautions which should be taken during hot weather practice sessions. It is felt that the knowledge which has been disseminated has been helpful in keeping Georgia from having any serious heat illnesses in recent years.

IMPROVED FORM FOR PRE-PARTICIPATION EVALUATION

Further attempts have been made to upgrade the pre-participation physical evaluation of athletes for participation in sports throughout the state and it is hoped that through the efforts of the committee a more meaningful and worthwhile form will be adopted by an increased number of schools.

NEW PROJECTS OF THE COMMITTEE

The committee would like to make two recommendations to the Georgia High School Coaches Association for possible implementation for the football season 1977. The first is medical coverage for high school football games.

RECOMMENDATIONS

A qualified physician should be on duty at each varsity football game and available but not necessarily present for all B-team and eighth grade games. The physician should be available preceding the game to evaluate any athlete regarding his playability. He should also be available on the field during the games to examine and perform any needed first-aid procedures. It is his duty to make one of the following decisions following any injury:

1) Determine that the player is capable of continued participation without increased risk of further injury or aggravation of existing injuries.

2) Determine that the player should not continue to play because of likelihood that further participation would likely result in aggravation of the injury or a more serious injury. If this decision is reached, then one of the following will be done:

a) Determine whether or not the injured athlete needs immediate referral to a hospital or other medical facility, or,

b) Determine that although the athlete cannot continue to participate in the game, his injury, while demanding medical attention and further evaluation at a later time, does not justify immediate transfer to a medical facility.

At halftime and following each game, each squad should be assembled in the dressing room and the physician, in the presence of the coach, should recheck each injured athlete. Each team must remain in the dressing room until all injured athletes have been checked and properly cared for.

Athletes who are wholly or partially ambulatory may be transported to the hospital or appropriate medical facility by auto. Serious and non-ambulatory cases should be transported by ambulance.

When the athlete is sent to a hospital or other medical facility, the referring physician should call the hospital or facility and notify them that an athlete with an injury is being sent to them and when possible, give the diagnosis. He should also notify the medical facility of the condition of the athlete at the time of referral.

RECOMMENDATION CONCERNING HEAD INJURIES IN FOOTBALL PLAYERS

a) Any athlete who is knocked unconscious during the course of a game will be removed from the game and not allowed to return. It is mandatory that he be checked by a physician during the game and if necessary, immediately following the game and if the condition justifies, then the patient should be removed to a medical facility for further evaluation.

b) Any athlete who is dazed, groggy, has loss of memory or other signs and symptoms of a head injury must be removed from the game and remain on the sidelines for observation by a physician for at least one quarter. The physician may keep the athlete out of the game longer if he feels that it is in the best interest of the athlete. This athlete should also be evaluated immediately after the game and if the condition so justifies, then he, too, should be sent for further evaluation at a medical facility.

This policy has been in effect at the Atlanta High Schools for more than five years now and it has eliminated a lot of controversy as to who should or should not be allowed to return to participation following a head injury. If this recommendation is accepted by the coaches throughout the state, and made mandatory, then it is the feeling of this committee that a very progressive step in the reduction in the number of serious consequences following head injuries can be eliminated.

RECOMMENDATION TO GEORGIA HIGH SCHOOL COACHES ASSOCIATION

It has been brought to the attention of this committee that during the most recent football season a number of football games, especially the game between Dougherty High School of Albany and Wayne County High School of Jesup, the weather conditions were such that the best interest of the athletes or the spectators could not possibly be served. While the health hazard probably was not nearly so great as the hardship placed upon the athletes and spectators due to the conditions, it is nevertheless felt by this committee that every effort should be made to allow for rescheduling of athletic events in case the weather constitutes a hazard as deemed by the medical authorities in the locale with consultation of coaches and athletic directors. We, therefore, recommend that the Georgia High School Athletic Association consider the advice of medical authorities within their area when the possibility of a health hazard exists.

SECTIONAL MEETINGS

The committee will encourage physicians throughout the state to sponsor local meetings on the Medical Aspects of Sports and will assist the local members whenever possible in providing material and speakers upon their request.

CONCLUSION

In conclusion, the committee would like to encourage each member of the Medical Association of Georgia to help develop the integrated relationship of health, education, and sports participation. There can be no question that one needs to be educated in order to develop and protect one's health and one needs abundant health to make full use of one's education. It is a reciprocal natural relationship that deserves the attention of every physician in Georgia.

REFERENCE COMMITTEE D

REFERENCE COMMITTEE RECOMMENDATION —The report of the Committee on the Medical Aspects of Sports is concerned with the prevention, recognition, treatment, and rehabilitation of injuries associated with organized sports activities. The first recommendation of the report is that a qualified physician be on duty at each varsity football game and available but not necessarily present for all B-team and eighth-grade games. The reference committee heard testimony that it is inconsistent to require a physician at varsity games and not at B games and that most of the injuries sustained in football occur in practice rather than in games. Your reference committee therefore recommends that the recommendation be amended to read, "Medical coverage of an athletic event should be the responsibility of the sponsoring organization, and an identified qualified physician should be readily available for care of injuries sustained in the event. Consideration should be given to using emergency medical technicians for this purpose." The recommendation in this section of the report goes on to list in detail a number of guidelines for the treatment of injuries sustained in games. Your reference committee believes that it is unnecessary and undesirable to dictate the manner of treatment to be used by physicians. Therefore, your reference committee recommends deletion of all recommendations with the exception of that already alluded to.

Mr. Chairman, your reference committee recommends adoption of the first set of recommendations as amended.

The report's second set of recommendations concerns head injuries in football players. Your reference committee suggests that the first part of these recommendations be amended to read, "Any athlete who is rendered unconscious during the course of a game or practice session will be removed from the game or practice session until examined by a physician. Your reference committee believes that the remainder of this set of recommendations is too detailed and unnecessarily over-directive for the physician treating the injured athlete and therefore recommends the deletion of this section of the recommendations.

Mr. Chairman, your reference committee recommends adoption of the second section of recommendations as amended.

The third recommendation speaks to the problem of weather conditions, such as lightning or excessive heat,

which present a health danger to participants in athletic contests. The recommendation is that the Georgia High School Athletic Association consider the advice of medical authorities within their area when the possibility of a health hazard exists.

Mr. Speaker, your reference committee believes this is a good recommendation and recommends adoption.

EDITORIAL NOTE: The House of Delegates adjourned at 5:30 p.m. until 9:00 a.m., April 24, 1977 at which time it resumed consideration of the Report of Reference Committee D.

HOUSE OF DELEGATES ACTION—The report of the Committee on the Medical Aspect of Sports contained three sets of recommendations. The House of Delegates acted on these sets of recommendations as follows: adopted the first recommendation as amended by the Reference Committee; received the second set of recommendations for information; and adopted the third recommendation.

COMMITTEE ON PUBLIC HEALTH (C45)

J. Gary Palmer, M.D.

The 1976 House of Delegates of the Medical Association of Georgia charged the Public Health Committee with the task of being a liaison between the Department of Human Resources and the medical community with specific reference to the conduction of the Swine Flu Immunization Program outlined at that time by President Ford.

Your committee chairman, along with the committee members and MAG staff members met on several occasions with the representatives from the Department of Human Resources concerning the Swine Flu Immunization Program.

Unlike the previous mass immunization programs, specifically the Sabin Polio Immunizations, the Medical Association of Georgia was not directly involved in the principal conduct of these immunization programs. The expense, both in time and money, of putting together such a large immunization program was entirely beyond the scope of the Medical Association of Georgia. The Department of Human Resources worked with a number of agencies, including the Center for Disease Control, in establishing the mass immunization program. Although the Department of Human Resources had complete control over this entire program, they did respect our specific expertise and frequently consulted with us for our specific input.

It is unfortunate that the Swine Flu Immunization Program was less than 100% successful; however, this was due largely to factors more related to adverse publicity than lack of effort on the part of the medical community or the Department of Human Resources. It is generally felt that the program, where operable, was an immense success, and did serve to provide low cost immunization to a large number of the high risk population.

The committee would like to make the following recommendations:

1. A letter of commendation from the Medical Association of Georgia be directed to Dr. James Alley and Dr. Charles Mosher favorably citing them and their agency for the job of successfully organizing and carrying out a massive immunization program of this magnitude.

2. The Committee on Public Health would like to continue to push for continued public awareness in the areas of pre-school immunization and polio immunization. There appears to be an increasing public apathy toward the presence of these dread diseases which have been controlled in the recent past by immunization programs.

3. The Committee on Public Health be continued as a special committee and be available for specific problems as realized by the governing bodies of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —The report of the Committee on Public Health describes the activities of the committee in supporting the swine flu immunization program. The first recommendation is that a letter of commendation from MAG be sent to Dr. James Alley and Dr. Charles Mosher, commending them and their agency for the job of successfully organizing and carrying out the massive swine flu immunization program.

Mr. Speaker, your reference committee recommends adoption of this recommendation.

The second recommendation calls for an effort to increase public awareness in the areas of pre-school immunization and polio immunization, toward which there now seems to be increasing public apathy. Your reference committee agrees that this problem should be addressed and wishes to recommend further that the matter be referred to the Subcommittee on Health Education for its action.

Mr. Speaker, your reference committee recommends adoption of recommendation 2 as amended.

Recommendation 3 calls for the Committee on Public Health to be continued as a special committee and to be available for specific problems as realized by the governing bodies of the MAG.

Mr. Speaker, your reference committee recommends adoption of recommendation 3.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Public Health with an amendment to recommendation number 2 that the matter of immunization as expressed in recommendation number 2 be referred to the MAG Subcommittee on Health Education for its action.

RESOLUTION 16
ANTI-SMOKING CAMPAIGN

DeKalb Medical Society

WHEREAS, statistics for the ten-year period, following the release of the report by the Surgeon General of the United States Public Health Service in 1964, indicate the total number of deaths in this country from just two diseases (lung cancer and emphysema) amounted to more than three-quarters of a million people; and

WHEREAS, cigarette smoking is the single, most preventable cause of lung cancer and emphysema, and that the evidence linking cigarette smoking to disease and death is now overwhelming; and

WHEREAS, cigarette smoking is again on the increase, particularly among teenage girls and young women: and

WHEREAS, we, as physicians, have a public responsibility to serve as exemplars and educators; and

WHEREAS, the Georgia Division of the American Cancer Society is requesting the support of all health professionals in the elimination of cigarette smoking, now therefore, be it

RESOLVED, that we, as examplars, attempt to eliminate cigarette smoking as a personal habit, and be it further

RESOLVED, that we acknowledge the role of cigarette smoking as a public health problem affecting the smoker, the non-smoker and the young; and be it further

RESOLVED, that we use our influence to eliminate cigarette smoking from all medical health-related facilities, i.e., hospitals, clinics, private offices, medical schools, medical meeting places, etc., and be it further

RESOLVED, that we will actively promote smoking cessation among our patients by demonstrating our concern for their well-being and reinforcing their efforts to stop cigarette smoking by counseling, by provision of educational materials, by eliminating smoking from all medical facilities, by instructing all personnel to refrain from smoking and by serving as examplars; and be it further

RESOLVED, that we use our influence to enact anti-smoking legislation within our local communities; and be it further

RESOLVED, that we will use our influence with other health-related professionals to gain their cooperation in anti-smoking efforts; and be it further

RESOLVED, that this resolution be distributed to all County Medical Societies in Georgia for their adoption and support.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 16, introduced by the DeKalb Medical Society, points out the serious dangers to health of cigarette smoking and calls upon physicians or take the lead in attempting to eliminate smoking from all medical health-related facilities (such as hospitals, clinics, private offices, medical schools, medical meeting places) and in reinforcing the efforts of patients to stop smoking by provision of educational materials and the instructing of personnel to refrain from smoking in medical facilities.

The resolution goes on to recommend that physicians use their influence to enact anti-smoking legislation within their local communities, to gain the cooperation of other health-related professionals in anti-smoking efforts, and to distribute this resolution to all county medical societies in Georgia for their adoption and support.

Mr. Speaker, your reference committee, hearing no opposition to this resolution, recommends that it be adopted.

HOUSE OF DELEGATES ACTION—Adopted Resolution 16.

RESOLUTION 21
SACCHARIN

Medical Association of Atlanta

WHEREAS, a controversy has recently arisen concerning the ban of saccharin by the F.D.A. under the Delaney Clause creating feelings among physicians that we are doing a tremendous injustice to the public and will not be meeting our obligations for preventive medicine, and

REFERENCE COMMITTEE D

WHEREAS, with the return of sugar to diet drinks and other foods, we can expect a significant increase in dental caries requiring additional expenditures for the care of these patients, and

WHEREAS, carious teeth lead to other medical problems which would further the extent of expenditures by both the government and the private patient, and

WHEREAS, there is no question that saccharin, and I might add other sweeteners, has been extremely important in the management of diabetic patients, and

WHEREAS, we will be placing these patients into additional jeopardy, which far exceeds the risk, as has been reported by the F.D.A., of bladder cancer, and

WHEREAS, there is no question that it is difficult to change basic habits, and

WHEREAS, we do not believe that the government is willing to spend the additional money that would be required to re-educate this large segment of the population, and,

WHEREAS, in relationship to dietary habits, our nation is one of overweight people and physicians do not believe that we can overnight correct dietary habits of the population as a whole, and

WHEREAS, saccharin has contributed its small part in maintaining the overweight population at the present level (for example, without it the diagnosis of "blimposis" would be more common), and

WHEREAS, urologists reported that studies done on workers in the manufacturing of saccharin in retrospective studies have not shown an increase in human bladder cancer,

NOW THEREFORE BE IT RESOLVED that the Medical Association of Georgia request that the F.D.A. rescind its directive on saccharin and any remedial legislation necessary be passed.

RESOLUTION 29
OBJECTION TO THE SACCHARIN BAN

DeKalb Medical Society

WHEREAS, diabetes mellitus and obesity pose severe health problems to the people of this country, and

WHEREAS, saccharin is the only artificial sweetener available for use, and

WHEREAS, there has never been a documented case of malignancy in humans caused by the use of saccharin,

THEREFORE, BE IT RESOLVED that this Association go on record as objecting to the ban on use of saccharin and directs its delegates to the AMA to urge that body to take such a stand and to urge all members of Congress to amend the Delaney Clause of the Food, Drug and Cosmetic Act to require proof of injury to humans before a drug or food can be banned.

AND BE IT FURTHER RESOLVED, that MAG make this stand known to and urge the Georgia members of Congress to press for such action.

REFERENCE COMMITTEE RECOMMENDATION —Reference Committee D considered together two resolutions dealing with the F.D.A.'s recent ban of saccharin

—Resolution 21 from the Medical Association of Atlanta and Resolution 29 from the DeKalb Medical Society. Since the resolutions are similar in pointing out the problems of the ban, your reference committee recommends that the two resolutions be consolidated into one. Since the MAA resolution is more comprehensive, reference committee recommends that its wording be followed with the addition of the following resolve, taken from the DeKalb Resolution, "that the MAG make this stand known to and urge the Georgia members of Congress to press for such action."

Mr. Speaker, your reference committee recommends adoption of the consolidated resolution as amended.

HOUSE OF DELEGATES ACTION—Adopted a consolidated resolution on the saccharin ban as written by the Reference Committee.

COMMITTEE ON MATERNAL AND INFANT HEALTH (C26)

Luella M. Klein, M.D.

(For Recommendations 1-3, see Report of Reference Committee C.)

RECOMMENDATION:

(4) That MAG be aware of the large numbers of adolescent pregnancies and the large number of legal abortions occurring within the State and assist in attempting to reduce these by adequate family planning facilities and services, sex education in the schools and all appropriate means.

REFERENCE COMMITTEE RECOMMENDATION —The report of the Committee on Maternal and Infant Health contains a recommendation number 4 that MAG be aware of the large number of adolescent pregnancies and the large number of legal abortions occurring within the state, and that it assist in attempting to reduce these by adequate family planning facilities and services, sex education in the schools, and all appropriate means. Your reference committee agrees with this recommendation and wishes to add further that the matter be referred to the Subcommittee on Health Education for its attention and appropriate action.

Mr. Speaker, your reference committee recommends adoption of the recommendation as amended.

HOUSE OF DELEGATES ACTION—Adopted the report of the committee as amended by the reference committee.

Chairman McGinnis expressed his appreciation to the members of the Reference Committee and to all those persons who appeared before the committee to express their views and to staff for their assistance in the preparation of this report.

REPORT OF REFERENCE COMMITTEE C

JACK A. RAINES, M.D., Chairman

Chairman Raines reported that Reference Committee C met on April 22, 1977, at the Hilton Hotel, Macon, Georgia, and considered all items referred to it. The members of the reference committee present were: Jack A. Raines, M.D., Columbus, Chairman; John T. Heard, M.D., Decatur, Vice-Chairman; Robert F. Coggins, M.D., Marietta; Albert A. Carr, M.D., Augusta; H. Hilt Hammett Jr., M.D., LaGrange; Franklin T. Bousquet, M.D., Savannah.

COUNCIL MAG'S QUALITY ASSURANCE CONTRACT (O/C6K)

Robert E. Perry, M.D.

WHEREAS, the Federal funding of the Quality Assurance Project ends June 30, 1977, Council recommends that the House of Delegates consider a continuation of this Program.

REFERENCE COMMITTEE RECOMMENDATION

Report O/C6K requests the MAG House of Delegates to consider a continuation of the MAG Quality Assurance Contract which is currently funded by federal funds and these funds expire June 30, 1977.

Your reference committee amended report O/C6K by substitution to read as follows:

"RESOLVED that the Medical Association of Georgia make available to the Quality Assurance Program funds not to exceed $35,000.00 from July 1, 1977 to July 1, 1978, and BE IT FURTHER

"RESOLVED that this allocation of funds be contingent on MAG Council approval at its May 1977 meeting, if supportive data shows sufficient interest and ability of hospitals in Georgia to participate in this program, hence, permitting MAG to recoup a reasonable amount of these funds."

Mr. Speaker, your reference committee recommends adoption of Council's report with amendments drafted and submitted by the reference committee.

HOUSE OF DELEGATES ACTION—Adopted the report of council O/C6K as amended by the reference committee.

RESOLUTION 12 MALPRACTICE LEGISLATION

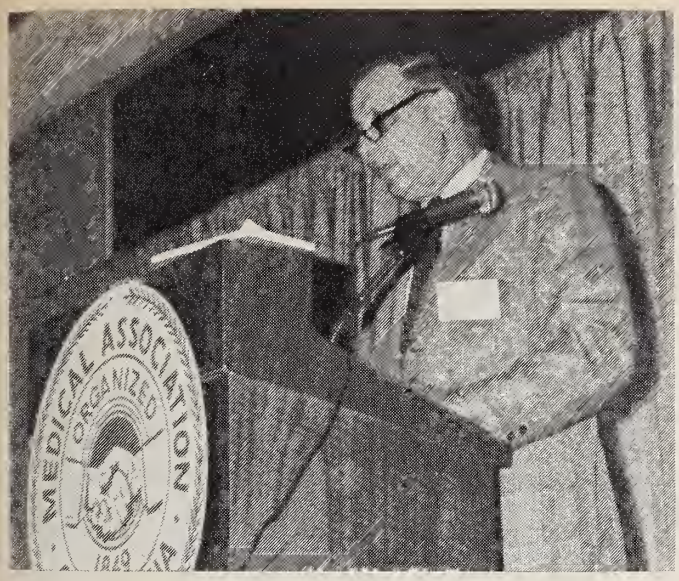
J. Robert Logan, M.D. for the Georgia Medical Society

WHEREAS, the cost of malpractice insurance continues to rise and

WHEREAS, the present method of judicial resolution of malpractice claims is inherently more costly, and offers no real advantage to arbitration, now therefore be it

RESOLVED, that the Medical Association of Georgia strongly endorse malpractice legislation that would allow for voluntary binding arbitration as an alternative to the traditional judicial resolution of malpractice claims.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 12 directs the Medical Association of Georgia to strongly endorse malpractice legislation that would allow voluntary binding arbitration. Your reference committee, carefully considering the testimony given before the committee, amended the resolution by addition as follows:



Speaker of the House, Dr. L. C. Buchanan

"BE IT FURTHER RESOLVED that the MAG House of Delegates instruct the MAG Insurance Committee to immediately begin an in-depth study on a voluntary binding arbitration system for Georgia and bring specific recommendations to the MAG Council in September."

Mr. Speaker, your reference committee recommends adoption of Resolution 12 as amended.

HOUSE OF DELEGATES ACTION—Adopted Resolution 12 as amended by the reference committee.

COMMITTEE ON MATERNAL AND INFANT HEALTH (C26)

Luella M. Klein, M.D.

During 1976 the Committee on Maternal and Infant Health met several times to review maternal death cases and abortion in Georgia and to discuss perinatal mortalities and maternal and infant health legislation. The Family Health Unit provided the following report about Georgia.

LIVEBIRTHS AND BIRTH RATE

There were 79,951 livebirths in Georgia in 1975. The birth rate decreased to 16.2, 13.9 white and 22.9 black. Preliminary data indicates that there was again a decrease of total livebirths in 1976.

There were 481 livebirths at home attended by lay midwives in 1975, and there were 1,162 deliveries in hospitals by Certified Nurse Midwives.

BIRTHS TO UNWED MOTHERS

There were 11,659 livebirths to unwed mothers during 1975. The rate rose to 145.8 per thousand in 1975.

ADOLESCENT PREGNANCIES

Livebirths to adolescents represented 24.7% of births in 1975. There were 9,114 livebirths to mothers under age 18 out of a total of 19,748 adolescent livebirths. Of livebirths to unwed mothers, 56.2% were to adolescents.

REFERENCE COMMITTEE C

MATERNAL MORTALITY

Nineteen women died as a direct or indirect result of pregnancy during 1975, thirteen black and six white. Ectopic pregnancy was the cause of death for three black women and two white women. Toxemia of pregnancy was responsible or contributory in the deaths of four women. Hemorrhage due to an acute inversion of the uterus caused the death of one patient and rupture of the uterus of another. Two women died following Caesarean section, one immediately following surgery and one 10 days after a Caesarean section-hysterectomy. Pulmonary embolism contributed to two deaths, one 2 months after a therapeutic abortion and the other 15 days postpartum. Massive pulmonary emboli were found at autospy in one patient who died at home. One death was attributed to amniotic fluid embolism, and late postpartum infection caused two other deaths.

INFANT MORTALITY

Infant deaths have continued to decline for the past 15 years. There were 1,466 infant deaths during 1975, a rate of 14.5/1000 livebirths for white and 25.2/1000 livebirths for black. White neonatal deaths have declined to a rate of 10.5 and postneonatal deaths to 4.0. For black infants the decline is to 16.5 for neonatal deaths and 8.7 for postneonatal deaths.

ABORTION

During calendar year 1975 there were 23,733 legal abortions reported to the Department of Human Resources, 19,907 patients were residents of Georgia, and 3,826 were out-of-state residents. This is an abortion ratio of 249 abortions per thousand livebirths. There were no deaths directly attributable to legal abortion.

Thirty-five percent of women aborted were under 20 years of age. Sixty-three percent were white and 35% black. Seventy percent of the patients stated that they were unmarried. Sixty-four reported that they were not practicing contraception prior to getting pregnant, and 15% reported at least one previous abortion. Eighty-nine percent of legal abortions were obtained under 13 weeks of gestation, 9% between 13 and 20 weeks, and less than 1% greater than 20 weeks. Three-quarters of the abortions were reported as "outpatient" procedures, and 89% were performed by suction curettage.

PUBLIC HEALTH MATERNAL SERVICES

During fiscal 1976, 13,557 women received prenatal care services through county health departments. The Program of Care for Medically Indigent High Risk Pregnant Women and Their Infants served 2,068 women and their infants during the fiscal year. This was a decrease of 33% from the year before but was due to greatly expanded services for newborn infants.

FAMILY PLANNING

As of June 30, 1976, there were 111,836 women actively participating in the Department of Human Re-

sources' statewide Family Planning Program. During fiscal year 1976 there was an unduplicated total of 134,336 patients served at 313,605 visits. Nearly one-third of patients were under 20 years of age. Oral contraceptives were chosen by 73% of the patients, intrauterine devices by 12% and other methods by 15%. There were 474 sterilization procedures paid for by program funds.

CERVICAL CANCER SCREENING PROGRAM

During fiscal year 1976, the statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Human Resources provided 133,757 Pap smears to indigent and medically indigent patients receiving health services from local health clinics. Since the beginning of the program in 1967, 569,265 Pap smears have been done, and a diagnosis of malignancy has been made in 1,081 cases. Ninety percent of all malignancies have been preinvasive.

RECOMMENDATIONS

1) That MAG support improved maternal health insurance legislation in Georgia.

2) That MAG support the adoption of legislation to be introduced in the legislature.

3) That MAG support the request to the legislature of the Georgia Council on Maternal and Infant Health for funds for care of the indigent and medically indigent mothers and infants in Georgia.

4) (See Report of Reference Committee D.)

REFERENCE COMMITTEE RECOMMENDATION —Report 26 requests MAG support for improved maternal health insurance legislation, adoption legislation and urges MAG support government appropriation of additional funds for the Georgia Council on Maternal and Infant Health for care of indigent and medically indigent mothers and infants in Georgia.

In reviewing this report, it was brought to our attention that Recommendation No. 1 and Recommendation No. 2 were accomplished by passage of legislation in the 1977 Georgia General Assembly and is therefore deleted by amendment by the committee.

Mr. Speaker, the reference committee recommends adoption of Committee Report 26 as amended by deletion.

HOUSE OF DELEGATES ACTION—Adopted the report of Committee on Maternal and Infant Health as amended by the reference committee.

COMMITTEE ON THIRD PARTY RELATIONS (C50)

Charles D. Hollis, Jr., M.D.

TALMADGE BILL

The committee began this year's deliberations with a study of Senator Talmadge's Medicare-Medicaid Amendments of 1976. Although the bill was not enacted into law, several of the sections reforming the two programs were passed and became law. The committee in its comments suggested some of the problems that the amendments might bring about as well as benefits. Suggestions for changing the amendments were also made. The recommendations included:

1) Supporting establishment of the office of Assistant Secretary for Health Care Financing Administration to centralize in one office various federal health programs.

2) Favoring appointment of an HEW Inspector-General for Health Administration to review, inspect and audit federal health programs.

3) Opposing linkage of increases in the prevailing fees for a locality with an economic index.

4) Strong opposition to requiring a signed participating physician agreement for Medicare.

5) Fully supported the specialty societies in their positions on reimbursement for hospital-based physicians.

A more detailed account of the committee's recommendations may be obtained from the MAG Headquarters.

CATASTROPHIC ILLNESS INSURANCE COVERAGE

The committee reviewed Catastrophic Illness Insurance Coverage legislation which had been enacted in several states. It was thought worthwhile to consider the development of such legislation for Georgia. By initiating such legislation in the state it might serve as an alternative to national health insurance, or might at least deter its enactment, or might be continued as a state program with local administration and some assistance from federal funding. An initiative by MAG in this area could lead to a better long term position for organized medicine in the state with consumers and state government.

At another meeting of the committee, Dr. Roy Rowland, state representative from Dublin, presented his bill on catastrophic insurance coverage. The committee made suggestions for changes and additions in Dr. Rowland's bill. One suggestion was that a level of comprehensive health insurance be mandated for all insured individuals and then the catastrophic coverage would be added on. Dr. Rowland's bill has been supported by MAG in the legislature. It is anticipated that after study during the year, the House may consider this legislation next year.

MINIMUM STANDARDS FOR HEALTH INSURANCE BENEFITS

The committee has begun to examine sets of minimum standards for health insurance benefits. This effort may result in a MAG approved set of basic benefits for health insurers, who could promote their plans which meet the standards as having MAG endorsement. The committee is working with the Georgia Medical Care Foundation in this study. While reviewing the standards, the committee has also considered the possibility of the Insurance Commissioner developing a system for labeling of insurance policies—e.g., comprehensive, basic, supplemental, etc. This possibility is being pursued through contact with the Commissioner.

CURRENT PROCEDURE TERMINOLOGY (CPT)

The committee has discussed the use of AMA's CPT coding system for treatments listed on claim forms by Medicare and other carriers. Georgia's Specialty Societies have been requested to comment on its use by their members. All of the carriers agree that MAG should encourage general use of the AMA's CPT code as a means of expediting claims processing. The physician should identify on the form the system of coding



Dr. Rupert H. Bramblett

being used. It was also emphasized that all of the commercial carriers could process their claims more promptly and accurately if the AMA standard claim form is used. These are available from Blue Cross/ Blue Shield and from the MAG printing office.

LIAISON WITH THIRD PARTIES

Mr. Ted Snyder of Prudential advised the committee that claim processing time had been reduced to an average of 8.9 days. There are usually about 6,000 claims that are 30 days old because they require additional documentation and have questions about eligibility or are under some sort of review. When problems are encountered with Medicare, Mr. Snyder suggests that he be contacted directly.

Medicare has changed the requirement for completion of the claim form when the physician accepts assignment. This includes not only writing in the amount charged, but also the amount paid by the patient to the physician. It was also pointed out that the physician can speed up the processing time for Medicare forms by filling them out for the patient, even when he does not accept assignment.

Physician profiles were updated on October 1, 1976, to reflect the 1975 calendar year. Prevailing fees are limited by an amount calculated with the use of the economic index.

In discussion of the attempt made by South Carolina's Medical Association to work with Medicare in establishing a statewide fee schedule, it was pointed out that the fees paid to urban physicians would probably not go up at the time of the next updating while those in rural areas would likely go up. Mr. Snyder advised the committee that in Arkansas a statewide fee schedule was being experimented with by Medicare. The Bureau of Health Insurance would have to be convinced that no additional costs would accrue to the Medicare Program in Georgia if they were to change to some other form of reimbursement to physicians. In Georgia the change to one prevailing fee limit for the entire state is likely possible.

REFERENCE COMMITTEE C

Many physicians' complaints about Medicare are related to the problems that Medicaid is having in payment of the combined claims. When a 1A Medicaid eligibility card is received, this indicates that the patient is over 65 and should be eligible for Medicare. The claim should be sent to Medicare. Delays have been encountered after the form has been sent to Medicaid.

Mr. Sam Thurmond, former Director of Medicaid, advised the committee that in fiscal year 1976, 366 million dollars had been budgeted for the Medicaid program. It was estimated that by 1980 one billion dollars would be expended for Medicaid. Medicaid accounted for 37% of the Department of Human Resource's budget.

One of the main problems with payment of claims by Medicaid was implementation of the Medicaid Management Information System (MMIS) in March of 1976. Although there are still many problems with the system, it is beginning to pay physicians on a routine basis. This now results in payment within 60-90 days. It was reported that there is being experienced a gradual but progressive decrease in the time of claims processing. Payment under Medicaid cannot exceed the limits allowed by Medicare and in early 1977 Medicaid was still reimbursing on the basis of 1973 profiles.

A fraud and abuse audit was begun by HEW in Georgia in October. The target period being looked at by the auditors is January, February and March of 1976. The auditors examined physician, pharmacy, hospital, nursing home, and lab claims. Mr. Thurmond indicated that he felt there is not very much fraud in the program, but that it is primarily a problem of abuse or overutilization.

Responding to a question concerning the cost of the program, Mr. Thurmond noted that physician reimbursements accounted for 12% of the budget and that nursing homes were approximately 40%. Administrative cost of the program is about 3%.

Mr. Thurmond explained several aspects of MMIS including the use of patient-physician-treatment profiles. There are institutional profiles mainly directed at lengthy stays. Another aspect of MMIS is the verification of claims. Many patients are receiving notices from Medicaid asking them if they in fact received Medicaid services from their physician. This is not the most effective use of a system and it could be done on a random sample basis in the future.

In discussing ways of changing the Medicaid program to better serve the interest of the patients and providers, Mr. Thurmond was asked who the contact people might be. He noted that this would depend upon the type of change that was being considered for the program, but that the best contacts would be in Senator Talmadge's office, Governor Busbee and someone Like Jack Watson in President Carter's administration.

AMBULATORY SURGICAL FACILITIES

The committee had referred to it a request from the Committee on Cost Accountability to look into licen-

sure or certification of ambulatory surgical facilities. In discussing this at the Third Party Committee Meeting, it was determined that this was not a very great problem at this time since only a few facilities were involved. The Blue Cross representatives advised the committee that they were developing individualized approaches in dealing with each such facility. The contract between the Blues and the facility would require certain standards to be met. The committee concluded that no action was necessary at this time on investigating certification or licensure. The Blues were asked to report periodically on the status of their arrangements with these facilities.

GEOGRAPHIC FEE DISCRIMINATION

It was pointed out during committee discussions that when government programs reimburse physicians at different rates for the same service, it is the patient who really suffers since when the physician does not accept assignment, the patient is responsible for the entire bill. The patient in the rural area is reimbursed by the government—a smaller proportion of his cost. There are fewer physicians interested in practicing in areas in which reimbursement is less and thus the problem of access for patients is worsened in these low paying areas. The committee felt that the same fee should be paid for the same services. It was felt that a single prevailing fee area for the state would be appropriate. The committee discussed alternatives as far as recommendations are concerned on the use of a statewide fee schedule for a single prevailing fee area. The committee suggested that in any action taken by the committee, it be emphasized that the main aim was to improve the availability of care in rural areas so that residents there would have equal access to care by having physicians more available. The committee pointed out that it is possible that by paying physicians higher reimbursement in urban areas the government may be compounding its problem by adding to the concentration of physicians and thus to the higher utilization of services in these areas.

The committee suggests the use of a statewide fee schedule or a single prevailing fee area for government programs' reimbursement to physicians. The committee has contacted the Bureau of Health Insurance about experiments with either of these alternatives in Georgia to determine their effect on the programs. Another possibility in addition to the statewide fee schedule or statewide prevailing is a supplemental payment to be made to physicians in lower fee localities. This payment would be made to bring their reimbursement from government programs closer to that made in higher fee localities.

Recently, the committee has become aware of an apparent policy change by the Bureau of Health Insurance on the use of localities to set prevailing fees. BHI allowed the carrier in Tennessee to establish a single prevailing fee area. Previously Tennessee had four areas:

1. Memphis SMSA
2. Nashville SMSA
3. Chattanooga, Knoxville and Bristol SMSA's
4. Remainder of state

This change was made at the request of the Tennessee Medical Association.

A Third Party Relations Committee meeting was held on March 9, 1977 with representatives of BHI present to discuss the possibility of Georgia's four areas being converted to a single prevailing fee area. The committee was advised that BHI would authorize such a change only if the cost to the government remained the same or decreased. If this was the finding, then at the next updating of physician profiles, the change to a single prevailing fee area would be made.

RECOMMENDATIONS

1. Encourage legislative action to provide catastrophic illness insurance at state level.
2. Continue to pursue possibility of establishing minimum standards for health insurance through labeling Insurance Commissioner regulations so that the public understands the coverage it is buying. Further, MAG consider endorsing policies which meet what is established as minimum standards.
3. Encourage general use of a CPT code by physicians' offices on their claims since all carriers agree this would expedite and improve accuracy in handling of claims.
4. Based on the information received from BHI and on previous House of Delegates' actions, your committee recommends that MAG proceed immediately to request:
   a. BHI to analyze the reimbursement data for Georgia and
   b. BHI instruct Prudential-Medicare to set one prevailing fee area for Georgia.

REFERENCE COMMITTEE RECOMMENDATION—Report C50 is a very comprehensive report dealing with a variety of topics. Recommendations include (1) Catastrophic Health Insurance; (2) Establishing Minimum Health Insurance Standards; (3) Encouraging general use of a CPT Code, and (4) Geographic Fee Determinations.

Due to other resolutions which refer to the subject matter of Recommendations 1, 2, and 4, your reference committee will only address itself to Recommendation 3, which would encourage general use of a CPT Code by physicians' offices on their claims. This CPT Code would be the adoption of a five-digit computer code which is now in use in numerous states.

Recommendation 1 will be considered with Resolution 6; Recommendation 2 will be considered with Resolution 7, and Recommendation 4 will be considered with Resolutions 5 and 31.

Mr. Speaker, your reference committee recommends adoption of Recommendation 3 of Committee Report 50.

HOUSE OF DELEGATES ACTION—Adopted recommendation number 3 of the Committee on Third Party Relations as recommended by the reference committee. (Recommendations 1, 2 and 4 are considered as described in the reference committee recommendation.)

THE AD HOC COMMITTEE TO STUDY THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS (C57)

Milton I. Johnson, M.D.

This committee is composed of Dr. L. C. Buchanan, Speaker of the MAG House of Delegates; Dr. James

H. Sullivan, First Vice President of MAG; and Dr. Milton I. Johnson, Second Vice President (Chairman).

We have met three times since our appointment on July 11, 1976. The Chairman met with the Legislative Committee on August 19, 1976. Both Dr. Buchanan and Dr. Sullivan have appeared before the Composite Board of Medical Examiners.

Our Committee feels that, for reasons that are not entirely clear, the State Board is not able to perform disciplinary functions in a timely manner.

Dr. James C. Dudley, President of the State Board, has stated that one of the main problems is money. According to the State Constitution, licensing board fees must go into the general treasury and cannot be used directly by the board which collects them. All of the boards collected 2.9 million dollars in fees, but the legislature only appropriated $750,000 for use by all the State Examining Boards in 1975. The Governor appropriated $50,000 in supplemental funds to the Composite State Board of Medical Examiners for fiscal year 1977 plus $105,000 in increased appropriation. The Board now has four investigators solely for their own use.

Dr. William J. Morton, who is both a member of the Composite Board and the MAG Legislative Committee, has stated that it takes $30,000-$40,000 in costs to revoke a physician's license.

RECOMMENDATIONS

The Composite Board of Medical Examiners should consider appointing the members of the MAG Executive Committee as Deputies of the Board with civil immunity. They could make recommendations to the Board as to the medical competency of a physician in question and the Board would then act forthwith with a timely decisive and appropriate disciplinary action.

Dr. William J. Morton of the State Composite Board of Medical Examiners has stated that this could be done by the Board.

We note that a Committee of the Executive Committee of MAG Council with the title of MAG Committee on Composite State Board of Medical Examiners was appointed by Executive Committee in December 1976. This Committee replaces the Ad Hoc Committee.

REFERENCE COMMITTEE RECOMMENDATION —Report C57 concerns the Composite State Board of Medical Examiners and ways that MAG could assist the Board. Due to the similarity of the subject matter between Report C57 and Resolution 8, your reference committee recommends the following:

Mr. Speaker, your reference committee recommends Report C57 be filed.

HOUSE OF DELEGATES ACTION—Report C57 filed.

RESOLUTION 8
COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

C. D. Hollis, M.D.
Dougherty County Medical Society

WHEREAS, the problems encountered by the Composite State Board of Medical Examiners has received considerable public attention in the past year, and

WHEREAS, there are basic problems within the present legislative direction and financial support of the Composite State Board of Medical Examiners, and

WHEREAS, the Medical Association of Georgia has appointed a committee of knowledgeable members of the Association to study and work in liaison with the Composite State Board of Medical Examiners, now therefore be it

RESOLVED, that the Medical Association of Georgia commend the Executive Committee for its decision to activate the Liaison Committee to the Composite State Board of Medical Examiners, and be it further

RESOLVED, that the Medical Association of Georgia transmit to the Governor and to the President of the Composite State Board of Medical Examiners a communication indicating its support and its feeling that quick and definitive action in improving the effectiveness of this body in monitoring and enforcing standards of practice in Georgia is urgent and should receive a position of high priority in executive and legislative support.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 8 begins to touch the surface of some of the numerous problems which the Composite State Board of Medical Examiners is experiencing in Georgia. These problems run from lack of financial support to lack of adequate personnel which results in action on urgent matters being postponed and delayed by the Board of Medical Examiners.

Your reference committee acknowledges the recent legislation which passed providing immunity to those persons, who, in good faith, report to the Board of Medical Examiners physicians, who in their mind, are not practicing the best of medical care. We also recognize the numerous committees which the Board of Medical Examiners appoints from the list of names submitted to them by the Medical Association of Georgia to assist the Board in the area of physician's assistants, institutional permits and temporary licenses. Your committee also recognizes the great need and importance of the recently appointed MAG Committee on Composite State Board of Medical Examiners, chaired by Charles E. Harrison, M.D., in hopes that this committee will work with the State Board of Medical Examiners and find reasonable solutions to some of the urgent problems which they face. In view of this, your committee has the following recommendation:

Mr. Speaker, your reference committee recommends adoption of Resolution 8.

HOUSE OF DELEGATES ACTION—Adopted Resolution 8.

RESOLUTION 1
USE OF DRUGS BY OPTOMETRISTS

DeKalb Medical Society

WHEREAS, the principles of medical ethics specify the responsibility of physicians to protect the public health, and,

WHEREAS, the invasion of medicine by non-medical practitioners jeopardizes the public health, and,

REFERENCE COMMITTEE C

WHEREAS, the American Medical Association's House of Delegates has adopted a resolution urging that state medical associations oppose any legislation or administrative attempt to give optometrists a license to prescribe or apply medications, or diagnose disease or injury, or to diagnose the absence of disease and injury; therefore, be it

RESOLVED, that the Medical Association of Georgia oppose any legislation that would authorize optometrists to engage in the diagnosis or treatment or to perform any type of surgery, or to use drugs or medication in any form for any purpose except when under the direct supervision of a licensed physician; and, be it further

RESOLVED, that the Medical Association of Georgia oppose any legislation which directly or indirectly extends the right to practice medicine or surgery to optometrists or in any way restricts or interferes with the proper practice of medicine and/or surgery by licensed physicians or surgeons.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 1 directs the Medical Association of Georgia to oppose any legislation that would authorize Optometrists to engage in the diagnosis or treatment of eye diseases or perform any type of surgery or to use drugs or medication in any form for any purpose except under the direct supervision of a licensed physician.

Your reference committee acknowledges the recent actions of the MAG House of Delegates in 1971, 1972 and 1974 relating to expansion of Optometric services in Georgia and MAG's position of opposition against this encroachment into the practice of medicine. Your committee realizes that not only Optometrists, but other para-health groups, are expending large amounts of monies to try to achieve, through the process of legislation, this expansion.

We fully acknowledge the serious problem of encroachment into the field of medicine and urge full support of every MAG member to actively oppose any legislation of this type.

Mr. Speaker, your reference committee recommends adoption of Resolution 1.

HOUSE OF DELEGATES ACTION—Adopted Resolution 1.

RESOLUTION 5
GEOGRAPHICAL FEE DETERMINATION

C. D. Hollis Jr., M.D.
Dougherty County Medical Society

WHEREAS, the MAG has been endeavoring to convince the AMA to work toward elimination of the discriminatory fee schedule under Medicare and Medicaid under the present system which delineates fees according to geographical areas, and

WHEREAS, this matter is still under discussion and study by the AMA without any decision about a position, and

WHEREAS, the physicians in Georgia feel that such fee delineation is undesirable for several reasons including its contribution to the problem of the maldistribution of physicians, the unfairness to physicians already established in rural areas and small towns, the unfairness being compounded by the fact that rural physicians perform many services often done in metropolitan hospitals by house staff and other hospital paid personnel, meaning that the small town and rural physician actually performs greater services for the smaller fee, and that the patient actually is affected most in a situation where there is direct billing and he is reimbursed for a smaller percentage of his cost if he happens to live in a rural area, and

WHEREAS, the many apparent advantages of practicing in metropolitan areas have little to offset them in the more thinly populated area, particularly when the physician who practices there does have a financial sacrifice, now therefore be it

RESOLVED, that the Medical Association of Georgia continue to encourage the AMA to ask for removal of the statutory and regulatory requirements for delineation of fees according to geographical areas within a state.

RESOLUTION 31
GEOGRAPHICAL FEE DETERMINATION

Robert W. Oliver, M.D. for
The Laurens County Medical Society

WHEREAS, the 1975 House of Delegates voted that "we should dedicate our efforts to see that every physician—urban, semi-urban, rural or institutional should be paid a fee for service without regard to geographic location," and

WHEREAS, the 1976 House of Delegates "adopted the report of the Rural Health Subcommittee with an amended second resolve that reads "Furthermore, that financial incentives be provided by equalizing fees regardless of geographic or population criteria," and

WHEREAS, the 1976 House of Delegates approved the recommendation of the Committee on Third Party Relations; "2. Notify Senator Talmadge and the other Georgia Representatives in Congress that the present fee differential based on geographical areas is discriminating and serves as a negative incentive for physicians to enter rural and thinly populated areas where their services are in great demand," and

WHEREAS, in the March 9, 1977 meeting of Third Party Relations Committee, representatives of the Bureau of Health Insurance stated that; for fees paid by Medicare to be equal throughout the state without regard to geographic location a request should be made to the Bureau of Health Insurance to analyze the reimbursement data for Georgia; and if the cost to the government remained the same or decreased then at the next updating of physicians' profiles, the change to a single prevailing fee area would be made, and

WHEREAS, this request does not of necessity have to come from MAG but can be made by any group of physicians, and

WHEREAS, MAG has not made this request to date, therefore be it

RESOLVED, that for the sake of unity and equanimity within the profession that the Medical Association of Georgia within the next two weeks request that:

a. The Bureau of Health Insurance analyze the reimbursement data for Georgia and

b. The Bureau of Health Insurance instruct Prudential-Medicare to set one geographic fee area for Georgia, and be it further

RESOLVED, that other Third Party Payors be encouraged to consider the same course of action.

REFERENCE COMMITTEE RECOMMENDATION —Resolution 5, Resolution 31 and Recommendation No. 4 of Report C-50 which address the same subject, were considered together. The State is currently divided into four areas with separate fee schedules for each area.

Your reference committee discovered that the fee difference between areas 1 and 4 averages only 6%.

The Medical Association of Georgia is a federation of physicians and it is important that we represent our entire membership without dissension. Your reference committee amended Resolution 31 by substitution as follows:

"RESOLVED, that the House of Delegates of the Medical Association of Georgia recommends the State of Georgia be designated as one geographic fee area, and be it further

"RESOLVED, that Council work with BHI to achieve this recommendation."

Mr. Speaker, your reference committee recommends adoption of Resolution 31 as amended and to file Resolution 5 and Recommendation No. 4 of Report C-50.

HOUSE OF DELEGATES ACTION—Adopted the reference committee recommendation with an amendment to delete the two resolves above and substitute in lieu thereof "Resolve, that the Medical Association of Georgia again endorses the concept of UCR and opposes the discriminatory application of this concept in the four Medicare fee areas of Georgia and further requests that council work with the BHI to analyze the reimbursement data for the State of Georgia and to establish one geographic reimbursement area."

RESOLUTION 6
CATASTROPHIC HEALTH INSURANCE

C. D. Hollis, M.D.
Dougherty County Medical Society

WHEREAS, there has been considerable discussion of the problems suffered by patients and families when struck by illness of catastrophic proportions which can produce financial ruin, and

WHEREAS, the United States Congress has had under discussion for several years plans for some nationwide catastrophic health insurance plan, and

WHEREAS, some six states now have established within the state plans for dealing with the problem of avoiding financial ruin in the case of catastrophic illness, and

WHEREAS, it seems possible that implementation of such catastrophic health insurance plans at a state level might offer an alternative to a national health insurance plan, or serve as a prototype for national plans developed and operated at a state level, now therefore be it

RESOLVED, that the Medical Association of Georgia encourage local and state legislative leaders to expedite plans for implementing such a catastrophic health insurance plan in the State of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Recommendation No. 1 of Report C-50 and Resolution No. 6 are on the same subject and were considered together.

Resolution 6 urges the Medical Association of Georgia to support a plan to expedite and implement a Catastrophic Health Insurance Program in Georgia. In so doing, MAG recognizes that such a program has been discussed on a national basis for numerous years in hopes that the feasibility of numerous states passing such legislation could circumvent National Health Insurance.

REFERENCE COMMITTEE C

Your reference committee, knowing full well the MAG position created in the House of Delegates in 1976 in opposition to any and all National Health Insurance, deliberated long and hard on Resolution 6. Your reference committee, in hearing the testimony presented by a State Legislator who is a physician, and others, substitutes a resolved to read as follows:

"RESOLVED, the Medical Association of Georgia endorses the concept of voluntary Catastrophic Health Insurance but adamantly opposes the government implementation of National Health Insurance by one federal act or 50 separate acts on a state basis, and therefore be it further

"RESOLVED, that the MAG House of Delegates instruct the MAG Committee on Third Party Relations to explore all avenues to increase voluntary participation in Catastrophic Health Insurance Programs."

Mr. Speaker, your reference committee recommends adoption of Resolution 6 as amended by substitution and that Recommendation No. 1 of Report C-50 be filed.

HOUSE OF DELEGATES ACTION—Delegate Charles Hollis moved to amend the report of the reference committee with the following resolution:

> **"RESOLVED, that the Medical Association of Georgia seek ways to support that small number of individuals who suffer financial ruin because of catastrophic illness."**

It was subsequently voted that the complete resolved portions of Resolution 6 be adopted as follows:

"RESOLVED, that the Medical Association of Georgia endorses the concept of voluntary catastrophic health insurance and instructs the MAG Committee on Third Party Relations to explore all avenues to increase voluntary participation in catastrophic health insurance programs, and be it further

"RESOLVED, that the MAG seek ways to support that small number of individuals who suffer financial ruin because of catastrophic illness, and be it further

"RESOLVED, that the Medical Association of Georgia endorses the concept of voluntary catastrophic health insurance but adamantly opposes the government implementation of National Health Insurance by one federal act or 50 separate acts on a state basis."

The House then voted to file Recommendation 1 of Report C50.

RESOLUTION 7
MINIMAL STANDARDS FOR HEALTH INSURANCE

C. D. Hollis Jr., M.D.
Dougherty County Medical Society

WHEREAS, the cost of medical care has continued

to rise at a rapid rate, and

WHEREAS, most people are dependent on their health insurance plans for reimbursement for costs of medical illnesses, and

WHEREAS, there is at present wide divergence in the adequacy of health insurance policies offered by various companies within the State of Georgia, misleading some patients as to the amount of coverage which they hold, and

WHEREAS, there are at present no documented minimal standards for the health insurance plan to be sold in the State of Georgia, now therefore be it

RESOLVED, that the Medical Association of Georgia encourage the Insurance Commissioner either through regulation or through new legislation and with cooperation of knowledgeable physicians within the Medical Association of Georgia development of a plan of minimum standards for health insurance policies.

REFERENCE COMMITTEE RECOMMENDATION —Recommendation No. 2 of Report C-50 and Resolution No. 7 are on the same subject matter and were considered together.

Resolution No. 7 urges the Insurance Commissioner of Georgia to work with members of the Medical Association of Georgia to develop a Minimal Health Insurance Plan which would enable Georgia citizens to know exactly what would be their minimum coverage on health insurance policies. The testimony before this committee recognizes the inability of the average citizen to adequately understand health insurance policies. Because of this, it is urged that every knowledgeable physician and interested person assist in any way possible to educate those persons to a minimum type of coverage for their health needs.

In view of this, the reference committee amends the resolved portion of Resolution No. 7 to read as follows:

"RESOLVED, that the Medical Association of Georgia encourage the Insurance Commissioner, in cooperation with knowledgeable physicians within the Medical Association of Georgia, to develop a plan of minimum standards for health insurance policies."

Mr. Speaker, your reference committee recommends adoption of Resolution No. 7 as amended and that Recommendation No. 2 of Report C-50 be filed.

HOUSE OF DELEGATES ACTION—Delegate Robert Wells moved to amend the resolve portion of the reference committee recommendation by deletion and substitution so that the resolve portion would then read: "Resolve, that the Medical Association of Georgia develop a set of minimum standards for health insurance policies." The first vote on the Wells amendment resulted in a 69-69 tie. A recount resulted in passage of the amendment 77 for and 69 against. Resolution 7 was thereby adopted as amended. Recommendation No. 2 of report C50 filed.

RESOLUTION 9
MEDICAID IN GEORGIA

C. D. Hollis, M.D.
Dougherty County Medical Society

WHEREAS, there have continued to be major problems in the administration of the Medicaid program in Georgia, and

WHEREAS, the changing of the top executives in the program has resulted in little improvement in efficiency in operation, and

WHEREAS, it seems apparent that the basic problem is in the inefficiencies of the large numbers of people who actually operate this program rather than in the top management, now therefore be it

RESOLVED, that the MAG encourage the Governor of Georgia to consider transmitting administrative responsibility for Medicaid from the present organization to that of a private insurance company or a medical care foundation with proven experience and effectiveness in handling medical claims.

REFERENCE COMMITTEE RECOMMENDATION —Resolution No. 9 urges the Medical Association of Georgia to encourage the Governor of Georgia to consider contracting out the Medicaid program to private insurance companies or medical care foundations to handle medical claims.

In the opinion of your committee, it is unlikely that any organization can adequately administer these programs under the restriction and regulations imposed by the Federal Government.

Mr. Speaker, your reference committee recommends Resolution No. 9 not be adopted.

HOUSE OF DELEGATES ACTION—Voted that Resolution 9 not be adopted.

RESOLUTION 11
REFORMS IN THE MEDICAID AND MEDICARE LAWS

C. D. Hollis, M.D.
Dougherty County Medical Society

WHEREAS, Senator Talmadge's Subcommittee on Health in the Senate is in the process of rewriting a bill on reform of Medicare and Medicaid programs, and

WHEREAS, many vital issues such as changes in types of fee schedules, the making available of health care services in remote areas, and methods of utilizing and monitoring allied health personnel are prominent in the discussions, and

WHEREAS, the Medical Association of Georgia has in the past been in communication with Senator Talmadge and his committee about various issues to be considered in reform legislation, now therefore be it

RESOLVED, that the Executive Committee of the Medical Association of Georgia refer the study of possible reforms in the Medicaid and Medicare laws to the appropriate committee for prompt and intensive study, and be it further

RESOLVED, that conclusions from such studies be forwarded as soon as possible to Senator Talmadge and his staff for consideration before the final draft of the bill has been completed.

REFERENCE COMMITTEE RECOMMENDATION —Resolution No. 11 urges MAG to study possible reforms in Medicaid and Medicare Laws in respect to legislation introduced in Congress last year and proposed legislation to be introduced in 1977. The results of this study would be forwarded to our senior U.S. Senator urging his support by our recommendations.

Your committee realizes that the Medical Association of Georgia Legislative Committee and the American

Medical Association Legislative Committee, in working with the different specialties in the different states, have on numerous occasions in the last six months visited Georgia's senior Senator and his staff and discussed with him the ideas of the AMA and MAG regarding his proposal to reform the Medicaid and Medicare laws. With this constant communication between the two professional associations and the members of the U.S. Congress, your reference committee feels the following action would be appropriate.

Mr. Speaker, your reference committee recommends Resolution No. 11 not be adopted.

HOUSE OF DELEGATES ACTION—Voted that Resolution 11 be not adopted.

RESOLUTION 15
STUDY AND EVALUATE MEDICAID

William E. Huger Jr., M.D.
Medical Association of Atlanta

WHEREAS, the Governor has seen fit to remove the Medicaid Department from the Department of Human Resources, and establish it as a separate unit of government, and

WHEREAS, recent information regarding the department leaves us with the confirmed conviction that the Medicaid system is still operating inefficiently and ineffectively, and

WHEREAS, there appear to be legal obstructions to a just debt incurred by the State for resubmitted claims of over two years duration, now therefore be it

RESOLVED, that MAG urge the Georgia General Assembly to conduct an in-depth study and investigation into the function of the Medicaid system in Georgia for the purpose of determining the causes of the ineffectiveness and inefficiencies, and rectify these errors by new legislation, as necessary.

REFERENCE COMMITTEE RECOMMENDATION —Resolution No. 15 requests MAG urge the Georgia General Assembly to conduct an in-depth study into the Medicaid system in Georgia and recommend to the Georgia Legislature appropriate actions. Due to the resolution previously discussed, the author of Resolution No. 15, Dr. William Huger, instructed the delegate from the Medical Association of Atlanta, Dr. Hugo Moreno, to withdraw Resolution No. 15. Therefore, Resolution No. 15 is withdrawn from consideration by your reference committee.

HOUSE OF DELEGATES ACTION—Resolution withdrawn.

RESOLUTION 18
NATIONAL HEALTH INSURANCE SURVEY

Hugo S. Moreno, M.D. for
Medical Association of Atlanta

WHEREAS, the Southern District of the Medical Association of Atlanta has conducted a survey to ascertain the opinions of the patients of the physicians in that area on the subject of National Health Insurance, and

WHEREAS, the results of this survey show overwhelming opposition to federal, compulsory, tax-financed health insurance, therefore be it

REFERENCE COMMITTEE C

RESOLVED, that the MAG study the feasibility of conducting a statewide patient opinion survey on the subject of National Health Insurance, and be it further

RESOLVED, that the information obtained from this survey be made available to the Georgia Congressional Delegation.

REFERENCE COMMITTEE RECOMMENDATION —Resolution No. 18 requests MAG to study the feasibility of conducting a statewide patient opinion survey on the subject of National Health Insurance and that the information obtained from this survey be transmitted to Georgia's Congressional Delegation. The basic concept of this Resolution was taken from a sample questionnaire distributed to numerous physicians' offices in the Southern District of the Medical Association of Atlanta. The results of the survey of those physicians in Atlanta illustrated to the committee that an opinion poll of some type did have considerable merit. For this reason, your committee amends by substitution Resolution No. 18 as follows:

"RESOLVED, that the Medical Association of Georgia study the feasibility of conducting a patient opinion survey on the subject of National Health Insurance by directing the MAG Council to appoint an opinion poll committee, and be it further

"RESOLVED, in the event that it is considered feasible, the MAG expend no more than $1,000.00 for said survey and that the survey be broken down by Congressional Districts, and be it further

"RESOLVED, that the information obtained from this survey be made available to the Georgia Congressional Delegation."

Mr. Speaker, your reference committee recommends adoption of Resolution No. 18 as amended by substitution.

HOUSE OF DELEGATES ACTION—Amended the reference committee recommendation by adopting a floor substitute to Resolution 18 as follows: "Resolve, that the MAG study the feasibility of conducting a patient opinion survey on the subject of national health insurance by directing the MAG Council to appoint an opinion poll committee, and be it further resolved, that in the event this committee finds such a survey feasible that the matter be referred to council for implementation and be it further resolved that if such a survey is obtained that the information from this survey be made available to the Georgia Congressional Delegation and to the members of the MAG."

RESOLUTION 30
ENERGY CONSERVATION

MacAlperin H. Arnold, M.D.
Elbert County Medical Society

WHEREAS, the United States of America faces critical questions relative to energy conservation, and

WHEREAS, national attention and concern has been focalized on this problem, and

WHEREAS, comprehensive programs are now being

developed at the highest levels of government to assure continued sources of supply for this vital natural resource, therefore be it

RESOLVED, that the Medical Association of Georgia supports constructive efforts to eliminate energy shortages in America, and be it further

RESOLVED, that the physicians of Georgia should use every means available to assure the success of these vital energy saving goals.

REFERENCE COMMITTEE RECOMMENDATION —Resolution No. 30 would indicate MAG support efforts to eliminate energy shortages in America by physicians using every means available to assure the success of vital energy-saving goals in recognition of a National Energy Crisis which our country faces today.

Mr. Speaker, your reference committee recommends adoption of Resolution No. 30.

HOUSE OF DELEGATES ACTION—Voted that Resolution 30 be not adopted.

COUNCIL AMENDMENT TO AMA'S COMPREHENSIVE HEALTH CARE INSURANCE ACT (O/C6B)

Robert E. Perry Jr., M.D.

The MAG delegation to the AMA House of Delegates asked Council for direction on the matter of urging an amendment to the AMA sponsored "Comprehensive Health Care Insurance Act." This act, which is the American Medical Association's version of national health insurance, was introduced in the Congress in January and the AMA sought suggestions from the State Medical Association on ways to improve the bill.

The MAG delegation (not unanimous) recommended to Council that this bill be amended to authorize a deductible payment for each service, both in-patient and out-patient, as a deterrent to over utilization of services by patients.

Council was reminded of the action of the House of Delegates in 1976 in adopting a resolution "that the Medical Association of Georgia take a firm stand against national health insurance in any form. . . ." Based on this prior action taken by the House, Council voted to refer the matter to the 1977 House of Delegates meeting.

Accordingly, the question before the House is: Shall the Medical Association of Georgia recommend to the AMA that the "Comprehensive Health Care Insurance Act" be amended to provide for a deductible payment for each in-patient and out-patient service rendered pursuant to this act.

REFERENCE COMMITTEE RECOMMENDATION —Report 6B recommends that the Medical Association of Georgia present to the AMA an amendment to the "Comprehensive Health Insurance Act" to provide for a deductible payment for each in-patient and out-patient service rendered under said act.

Your reference committee realizes the actions taken on Resolution No. 12 of the 1976 House of Delegates which emphatically states, "the Medical Association of Georgia is opposed to any form of National Health Insurance."

In view of the action taken by the 1976 House of Delegates, your reference committee has the following recommendation.

Mr. Speaker, your reference committee recommends Report 6B not be adopted.

HOUSE OF DELEGATES ACTION—Voted that Report of Council O/C6B be not adopted.

Chairman Raines expressed his appreciation for the members of the Reference Committee and to all those who appeared before the committee to express their views and to the staff for their help in the preparation of this report.

REPORT OF REFERENCE COMMITTEE B

RONALD F. GALLOWAY, M.D., Chairman

Chairman Galloway reported that Reference Committee B had met on April 22 at the Hilton Hotel in Macon, Georgia and had given careful consideration to all the items referred to it.

Members of the Reference Committee present were: Ronald F. Galloway, M.D., Augusta, Chairman; James H. Smith, M.D., Rome, Co-Chairman; Frank W. McKinnon, M.D., Marietta; James A. Kaufmann, M.D., Atlanta; E. A. Quarterman, M.D., Atlanta; Alexander H. S. Weaver, M.D., Macon.

RESOLUTION 28 AMA MEMBERSHIP OPINION POLL REGARDING NATIONAL HEALTH INSURANCE

DeKalb Medical Society

WHEREAS, the American Medical Association has been given a charge by its House of Delegates that "the membership be polled for their opinions on critical issues facing the medical profession," and

WHEREAS, previous polls, conducted by AMA (including the one recently distributed) have not asked the membership whether they favor National Health Insurance or whether they feel that the AMA should sponsor a National Health Insurance Plan, and

WHEREAS, neither the economy nor the presently available health manpower can withstand the advent of National Health Insurance resulting in rationing of health care and leading to unnecessary suffering and financial burden for our patients, and,

WHEREAS, the implementation of National Health Insurance is *the* most important issue facing organized medicine today, therefore be it

RESOLVED, that the Medical Association of Georgia take a firm stand against National Health Insurance in any form, and be it further

RESOLVED, that MAG go on record in opposition to AMA's sponsorship of a National Health Insurance proposal, and be it further

RESOLVED, that MAG introduce a resolution at the June 1977 Annual Meeting of the American Medical Association directing the AMA to immediately conduct a membership opinion survey that asks the following two questions:

1. Are you in favor of the enactment of a National Health Insurance program in this country?

2. Do you believe the American Medical Association should sponsor a National Health Insurance proposal?
and be it further

RESOLVED, that this resolution also state that if the results of this survey reveal that the physicians of this country oppose National Health Insurance and AMA's sponsorship of an NHI plan, the American Medical Association immediately withdraw its NHI legislation (HR 1818-S218—Comprehensive Health Care Insurance Act of 1977).

REFERENCE COMMITTEE RECOMMENDATION —This resolution considers positions to be taken by MAG and AMA on national health insurance.

1) The first resolve proposes that MAG oppose national health insurance in any form. The second resolve proposes that MAG oppose AMA's national health insurance plan. Your Committee feels that the purpose of these two resolved portions was accomplished by action of the 1976 House of Delegates.

In order to re-enforce MAG's position, Mr. Speaker, your Committee recommends adoption of a substitute resolve:

"The MAG reaffirms its stand against national health insurance in any form."

2) The third resolve proposes that a resolution be submitted to AMA offering questions to be included in a membership opinion poll. There was general support for this. A representative of the society which introduced the resolution agreed to an amendment substituting "December" for "June" and "Interim" for "Annual."

Mr. Speaker, your committee recommends adoption of the third resolve as amended.

3) The fourth resolve calls for AMA to withdraw its NHI plan if the results of the opinion poll indicate a majority of physician opposition. The committee agreed with a technical amendment proposed during our hearing to change the word "and" to "or," so that AMA's action on its NHI plan would be contingent on the response to either of the two questions.

Mr. Speaker, your committee recommends adoption of this resolve as amended.

HOUSE OF DELEGATES ACTION—Adopted Resolution 28 as amended by the reference committee.

COMMITTEE ON MEDICAL PRACTICE (C31)

W. Daniel Jordan, M.D.

During the past year the committee has reviewed several items of general interest which are presented below together with recommendations.

UTILIZATION REVIEW REGULATIONS

The committee reviewed the Utilization Review regulations issued in May 1976 for Medicare and Medicaid. The committee concluded that MAG should have a general objection to requiring all hospitals to comply with the Utilization Review Regulations. Many hospitals are able to perform adequately without complying with such detailed regulations. It was suggested that MAG ask HEW to provide a variance for facilities that could demonstrate their competence in this area.

The committee drew up a resolution concerning

REFERENCE COMMITTEE B

MAG's response to the UR regulations for submission to the AMA. This resolution was approved by the MAG Council.

RESOLUTION ON UTILIZATION REVIEW

WHEREAS, universal application of mandatory Admission Review (AR) and Continued Stay Review (CSR) provisions will require substantial additional clerical and professional review work for many hospitals, and

WHEREAS, many hospitals already have demonstrably effective utilization review systems which vary widely in methodology and staffing, and

WHEREAS, many of these flexible hospital-developed systems are considerably less expensive and require much less physician review time than the system proposed in the Utilization Review Regulations, and

WHEREAS, economy, flexibility and effectiveness should be the goal of UR Regulations,

NOW THEREFORE BE IT RESOLVED that the AMA strongly urge the Secretary of Health, Education and Welfare to apply mandatory AR and CSR provisions only to those hospitals which have *not* demonstrated and continue not to demonstrate on a quarterly basis an ability to insure proper utilization of services (e.g. error % of less than "X" percent, analogous to, or the same as, the 5% error rate used in Medicare waiver determinations) and that all other hospitals be allowed to carry out UR in whatever effective manner they see fit.

This resolution was sent to the AMA by the MAG. The AMA House of Delegates, after review of this resolution, adopted a substitute resolution which reads as follows: "Resolved that the Board of Trustees be commended for its continuing Utilization Review, and be instructed to take appropriate action including further legal action, if necessary, to protect the quality of care and insure against federal intervention into the physician-patient relationship when the final Utilization Review Regulations are published."

CLOSED HOSPITAL MEDICAL STAFFS

The committee reported to last year's House of Delegates on the problem that could occur in some areas when a hospital closes membership on its staff. This question was referred back by the House to this committee for additional study. The following comments on this issue are from the MAG legal counsel:

"You have asked our advice concerning the legal aspects of any extension by hospitals or existing practices to employ a specific physician or group of physicians on a contract basis to render specialized services at the hospital.

"The basic issue presented involves the extent to which a hospital has the legal right to contract with a group of physicians to provide patients utilizing said hospital with all services required in a given medical specialty thereby excluding all other physicians from

utilizing that hospital's facilities for the purpose of providing such special care." This letter is a short summary of a legal memorandum prepared by Gary G. Grindler of our office.

When a hospital decides to contract for a given specialty, physicians who already hold staff privileges at a hospital may lose them or have their practice restricted, and physicians without staff privileges may face summary denial when applying for staff privileges in the specialty contracted for by their hospital. The legal questions raised in this situation involve application of (a) the United States Constitution, (b) the federal antitrust laws, and (c) certain principles of common law.

A. CONSTITUTIONAL CONSIDERATIONS

1. *Procedural Due Process.* It is well established that decisions by a *public* hospital involve "state action" and necessitate a due process hearing. With respect to private hospitals, the law is not so well established, but the trend appears to favor the giving of a due process hearing—either because the hospital receives Hill Burton money or the hospital receives public benefits and virtually monopolizes the delivery of care in a given community.

2. *Equal Protection.* Assuming that "state action" is present, an aggrieved physician could argue that a hospital's decision to contract solely with others for a particular medical specialty violates the equal protection clause. Such arguments, however, have met with little success in the past. Cases have stated that the equal protection clause is not violated if the hospital's decision "has a reasonable purpose and embodies a reasonable means of achievement," "is reasonably related to the operation of the hospital and fairly administered," or "geared by a rationale compatible with hospital responsibility, and unencumbered with irrelevant considerations." Some of the factors which courts have cited with approval in upholding a hospital's right to make such contracts are (a) the hospital's interest in supervising various functions to avoid liability for negligence, etc.; (b) the hospital's interest in efficient use of expensive equipment by limiting use of certain personnel and by scheduling use of the equipment; (c) the public interest in maintaining competence levels for certain procedures by concentrating the work to a small group; etc.

In summary, the courts consistently allow hospital governing boards wide latitude in making decisions which arguably affect the quality or efficiency of medical care. The few cases which have considered the validity of hospital/physician contracts have involved what may be termed hospital based services including departments of radiology, pathology and nuclear medicine. In all cases, the courts upheld the contract as reasonable although some emphasis was placed on the type of specialty involved as well as the fact that in some cases the plaintiff could still practice medicine, albeit in a more restricted fashion.

B. ANTITRUST CONSIDERATIONS

Beyond the question of equal protection, aggrieved physicians could challenge hospital contracts under the Sherman Antitrust Act based upon a theory of a concerted refusal to deal on the part of the hospital and the contracted group of physicians.

1. *Procedural Questions.* Before reaching the substantive issue, some jurisdictional questions would have to be overcome by the complaining physicians. First, the activity involved must be considered "trade or commerce." A recent Supreme Court decision indicates a willingness to regard the professions as being engaged in trade or commerce, and we assume that the existence of trade or commerce would not present a serious obstacle to relief under the antitrust laws. Second, the excluded physicians would have to prove a conspiracy on the part of the defendants. This issue may depend on whether the contracting physicians are *employees* of the hospital or *independent contractors*. If they are independent contractors, it will probably be possible to construe the action by the hospital as a conspiracy. We are assuming that the other jurisdictional prerequisites ("interstate commerce" and the fact of injury) would be present.

2. *Substantive Considerations.* On the substantive level, the Sherman Act was passed to prohibit unreasonable restraints upon trade. If a hospital and its contracted group of physicians have an intent to exclude physicians as competitors, this would be a *per se* violation. Given the fact that having the exclusive right to perform a particular medical specialty at a hospital in effect gives the contracted group of physicians a "captive audience" who must pay them for necessary services, an inference of an intent to exclude other physicians is certainly reasonable.

If not within the *per se* category, a factual injury will have to be made to determine the reasonableness of a hospital's decision to contract with a specific group of doctors. This inquiry would focus upon the relationship between the privilege to practice in a hospital and the continued viability of an independent physician's private practice. It would also consider whether there were any business or medical justifications such as the factors described above with respect to equal protection. A plaintiff would have to show that this contractual relationship constituted an "unreasonable restraint upon trade."

C. COMMON LAW CONSIDERATION

A possible common law action, analogous to the antitrust action, is entitled intentional interference with the right to establish and conduct a lawful business or engage in a lawful profession. As with the *per se* rule under a refusal-to-deal theory, an intent to interfere with that right without excuse or justifiable cause will have to be proven.

In summary, there are several legal theories which would be available to challenge any extention of this practice by hospitals. Unfortunately, all of the theories require a heavy burden of proof in order to be successful."

Based upon these comments, the committee submits again its recommendation on this issue. (See below.)

REVIEW OF MEDICAL STAFF BYLAWS

At the AMA Clinical Meeting in Philadelphia, the House of Delegates adopted a report urging state medical associations to assume more responsibility toward their membership in reviewing hospital bylaws with the goal of protecting the rights of the physician members of the staff. The MAG's delegation to AMA asked the Medical Practice Committee to consider this activity.

The committee agrees that the MAG and its legal counsel should offer the review of changes in their Bylaws as a service to hospital medical staffs. The MAG would be used as an accrediting agency for Bylaw amendments. This would serve to protect the physicians in their hospitals where there may be opposing opinions expressed by administration, hospital authority or owners of the facility. The Medical Practice Committee would be used as the reviewing group for the Bylaws. Funds have been requested in the budget for the committee to reimburse the MAG attorneys for their time and effort as the committee felt was necessary. Upon approval of the House of Delegates, hospital staffs would be notified of this service. (See below.)

JCAH STANDARDS

The committee has on three occasions reviewed proposed changes in JCAH standards for accreditation of hospitals. The JCAH now routinely send these proposals to MAG. In two cases no comment was made by MAG. In the case of the proposed medical staff section of standards for accreditation, numerous changes were suggested. The committee expects to continue performing this review on proposed revisions of JCAH standards.

BLUE CROSS—ATLANTA UTILIZATION REVIEW PILOT PROJECT

Atlanta Blue Cross has been experimenting with conducting Utilization Reviews in several hospitals in its area. The results of this pilot project are to be made available soon. If they can be obtained by MAG, a supplemental report of the committee will be presented to the House on the project.

RECOMMENDATIONS

1. That House of Delegates adopt the following policy concerning contractual relations between hospitals and physicians for the delivery of medical services.

a) The freedom and right of the patient to choose his doctor and the right of the doctor to choose his patient (true emergency situation excepted) should be recognized.

b) The establishment of contractual relations between any physician(s) and the hospital should be subject to the approval of the medical staff.

c) All physicians included in a contractual relationship are to be members of the medical staff of that hospital.

2. The MAG should offer to hospital medical staffs the opportunity to have the Medical Practice Committee review medical staff bylaw changes.

REFERENCE COMMITTEE RECOMMENDATION —This comprehensive report discusses MAG's introduction of a resolution on utilization review, the problem of closed hospital staffs, review by MAG of hospital medical staff bylaw changes, and the committee's review of proposed changes in JCAH standards for accreditation. This committee is to be commended for its fine work on behalf of all physicians.

The first recommendation of the committee deals with an issue considered by last year's House and referred back to the committee for additional study. A lengthy legal opinion on contractual relations between hospitals and physicians is included in the report. The reference committee concurs with the concern expressed in the first recommendation. Part a. recognizes the doctor's and patient's freedom of choice. Part b. subjects hospital and physician contracts to approval by the medical staff.

Mr. Speaker, your committee recommends adoption of recommendation 1. a and b.

Item 1 c requires medical staff membership for all contracting physicians. Your reference committee felt that this part of the recommendation should be clarified to exclude some physicians and to allow various categories of medical staff membership. The committee substitute for 1 c would read:

"All physicians (except those in approved training programs) included in a contractual relationship are to be members of some category of the medical staff of that hospital."

Mr. Speaker, your committee recommends adoption of part 1 c of recommendation 1. as amended.

The Medical Practice Committee proposes in the second recommendation to offer a new service to medical staffs of hospitals. The reference committee learned that in some localities, a medical staff may be in conflict with a hospital administration, authority, or owners. In such cases the Medical Practice Committee and MAG legal counsel could assist the hospital medical staff in reviewing staff bylaws. This would assure that the bylaws were in the best interest of the medical staff.

Mr. Speaker, your committee recommends adoption of Recommendation 2.

HOUSE OF DELEGATES ACTION—Adopted the recommendation contained in the report on the Committee on Medical Practice as amended by the reference committee.

REFERENCE COMMITTEE B

MEDICAID NEGOTIATING COMMITTEE (C27)

J. Dan Bateman, M.D.

The Medicaid Negotiating Committee presents this report to the 1977 House of Delegates to summarize the Medicaid situation that has existed in Georgia since May of 1975, and to present specific recommendations to the House on the MAG's future attitude toward Medicaid. Detailed information concerning the negotiations that have occurred over the past two years between MAG and the Medicaid agency may be obtained from the MAG Headquarters office.

ORIGINS OF MEDICAID DISPUTE

In May of 1975 the MAG, without prior notice, received from the Department of Human Resources, a document entitled Physician Services, Policies and Procedures Manual Draft which established the requirement for signing a Provider Agreement as well as an agreement to comply with the policies set down in the Manual. The MAG vigorously protested the manner in which the Manual and Provider Agreement were developed and presented to the Association. Specific ob-

jections were raised on various sections of the Manual and attempts were made by the MAG Executive Committee to contact the physician members of the Board of Human Resources to discuss this problem with them.

After unsuccessful attempts to change the effective date of the Manual and failure of discussions on the various provisions therein, the MAG Council in June of 1975 appointed a committee to study the problem, attempt to make modifications in the Agreement and the Manual and report back to Council. Subsequently, numerous special called meetings of Council as well as regularly called meetings of the Council and the Executive Committee were taken up with discussions of changes which were proposed in the Manual and the status of the discussions between the MAG and the state agency. During these series of meetings, the ad hoc Committee on the Medicaid Manual and Physician Provider Agreement presented a report to Council which concluded that changes had been made in the Manual, but that there were still objectionable portions in it as well as in the Provider Agreement.

It was determined by Council in July of 1975 that the changes were not sufficient to warrant participation in the program by MAG members. At that meeting consideration was given to filing a law suit against the state. In September of 1975 the Council did vote to file suit against the state to obtain relief from the imposition of the Medicaid Provider Manual and Agreement by the Department of Human Resources.

MAG VERSUS MEDICAID

The Council decision in September of 1975 to file a lawsuit against the state was based on the Association's contention that the Agreement and Manual:

1. Interfered in the patient-doctor relationship by imposing the state in the physician's practice and interfering in his ability to treat the patient according to his best judgment;
2. Deprived the Medicaid-eligible person from access to quality medical care as provided for in the Social Security Act by establishing dual standards for care and by dictating modes of treatment;
3. Restricted the Medicaid-eligible patient's access to medical care by discouraging physicians from participating in the Medicaid program through the requirement for signing a contract with the state to provide services to Medicaid patients at the direction of the Medicaid agency;
4. Infringed on the physician's right to expect equal treatment under the federal and state laws by including in the contract provisions which might result in failure to reimburse the provider for services rendered either through factoring or through the unavailability of funds.

During the next year, the MAG attorneys with the assistance of MAG officers and staff conducted preparations for the actual presentation of briefs before the court as well as the court appearance. After lengthy preparation and several delays, the lawsuit was scheduled for a hearing in September of 1976. Prior to the trial date, the MAG attorneys and the attorneys for Medicaid came to an agreement which was presented to their respective clients. Our attorneys advised us that in their opinion a settlement had been achieved which in all likelihood was more favorable than any anticipated court decision that might be granted in favor of the MAG at some future date. The basis for the settlement by the attorneys were the principles which has been identified as the basic items upon which MAG could agree with the state. These included:

1. Maintaining records;
2. Documenting services that are billed;
3. Accepting judgment by Medicaid on the necessity, appropriateness and cost of services as determined by true peer review;
4. Recognizing that DHR had the final say-so in all matters regarding Medicaid patients and that they could separate physicians from participation in the Medicaid program at their discretion.

Our legal counsel's presentation to the MAG Council in September of 1976 expressed his belief that this was the best settlement that could be achieved by MAG. Based upon this recommendation, the Council accepted the settlement of the lawsuit against the state. As part of the settlement, the state and MAG agreed to the elimination of the provider agreement and substituted for it a statement of participation which was agreed to by legal counsels for both parties. The statement of participation recognized that it,

> "Shall in no way be considered or construed to dictate or purport to dictate or to prescribe the manner in which the physician shall conduct his practice of medicine; such—the statement—only establishes the means and terms of reimbursement between the undersigned physician and the state agency."

By signing the statement, the physician agreed to participate in the Medicaid program and to keep and make available to the state agency such records and information as necessary to comply with Federal regulations set for Medicaid. Further, the physician agreed to accept as payment the amount set as the reimbursement for Medicaid by the Department of Human Resources. The provider recognized that the state and the federal government were released from their obligation to reimburse him if the funds were not appropriated in sufficient amounts to cover the obligations of Medicaid. Finally, any material changes in the Medicaid program had to be presented to the physician in advance of their taking effect and the physician agreed to give notice to the state if he were to decide to cease his participation in the program.

The second portion of the settlement calls for the MAG and the state agency to conduct negotiations on the contents of what was then called the Georgia Medical Assistance Program Policies and Procedures for Physicians Services, i.e., the manual.

NEGOTIATIONS BETWEEN MAG AND MEDICAID

This Medicaid negotiating committee, reappointed by Council in September of 1976 has been working diligently since that time to fulfill that second part of the settlement agreed to by MAG and state. After numerous meetings of the committee, and negotiating sessions between MAG representatives and representatives of the state, we have reached a point in time when it appears that the results achieved by the committee in its negotiations with Medicaid should be reviewed by the House of Delegates.

Although the language of the policies has not been finalized, certain mutually agreed upon principles have been achieved during the negotiating sessions. The completely revised policies which must be issued at a future date will have to be reviewed by this committee or a successor committee to be sure that the proposed language is consistent with the principles that have

been agreed upon during the negotiations.

The results of the negotiations thus far reflect an honest effort by both parties to achieve a set of policies that are in the best interest of the patient, that reflect the concern of the state for accountability in the program and that offer a reasonable framework for physicians to practice their profession. By no means will the policies totally satisfy all parties. They have been established in a spirit of compromise based on negotiations conducted in good faith by the MAG and Medicaid. The committee has been encouraged by the negotiations that have occurred. A brief description follows of the agreement that has been reached on certain policies that have been considered during the negotiations.

1. The participating physician is no longer required to submit a copy of his medical license, nor is he required to designate himself as a specialist or a general practitioner.

2. Although the Georgia Administrative Procedures Act does not apply to Medicaid, the commissioner has indicated that similar procedures will be established for Medicaid to assure that providers are given due process in any decisions that are made concerning a reimbursement and participation in the program.

3. At this time, no specific minimum record keeping requirement is delineated in the policies.

4. Third party payment may be made to the physician and may be accepted by the physician in lieu of payment by Medicaid.

5. The phrase, "the concept of the prudent buyer" has been deleted from the policies.

6. The Foundation is recognized as the Medicaid's Peer Review mechanism.

7. Although the principle of prior authorization will be retained in the policies, this section will allow Medicaid to periodically set a procedure as one requiring prior approval. This determination might be based on Medicaid analysis of Georgia data compared to national data, or based on the Foundation's findings.

8. The Provision for factoring has been deleted.

9. The guidelines for office visits has been changed from one to two per month.

Numerous other changes have been made in the manual. The specific language to incorporate these changes into a document that can be reviewed by both parties will be prepared and presented in the near future by the state to MAG.

In spite of the progress that has been made during these negotiations, the committee still has certain reservations about participation by physicians in the Medicaid program. In particular, the committee has serious concern for any general pronouncement by MAG which might be construed as unanimous approval of the concept of a Statement of Participation and the Physician Reimbursement Policy. Because of these concerns, the committee recommends: The committee cannot at this time give blanket endorsement of the Physician Statement of Participation and the Physician Reimbursement Policies as advanced by the Georgia Medical Assistance Program. Therefore, the recommendation of the committee is that the decision to sign a statement of participation must be made by each individual physician after the Physician Reimbursement Policy, as negotiated, has been forwarded to physicians by the commissioner of the Georgia Medical Assistance Program.

REFERENCE COMMITTEE RECOMMENDATION —In addition to having this excellent report before it, the reference committee was addressed by the chairman of this committee. He presented additional information on the background of the Medicaid problem and negotiations that have occurred. The committee also had the benefit of remarks made by the Commissioner of the Medicaid agency. His comments expressed a willingness to continue the open communication which has transpired thus far.

The Medicaid Negotiating Committee urges adoption of a policy that each physician decide for himself whether he should participate in Medicaid after reviewing the revised Physician Reimbursement Policies and the Statement of Participation.

The members of the Medicaid Negotiating Committee deserve the commendation of the MAG.

Mr. Speaker, your committee recommends adoption of the Medicaid Committee's recommendation.

HOUSE OF DELEGATES ACTION—Adopted the recommendations of the Medicaid Negotiating Committee.

REFERENCE COMMITTEE B

RESOLUTION 25
PHYSICIAN RECRUITMENT BY HOSPITALS
Ware County Medical Society

WHEREAS, the Ware County Medical Society considers private practice of medicine to be a cornerstone for delivery of health care in a local community and

WHEREAS, it is essential that physicians in all communities be allowed complete freedom to render adequate care and to set their own fees commensurate with services rendered and

WHEREAS, there appears to be a move in our state for some hospital authorities to entice physicians to relocate in Georgia by offering a contract which contains many attributes of the corporate practice of medicine, now therefore be it

RESOLVED, that the Medical Association of Georgia deplores the unfair practices of some hospital authorities in enticing physicians to their area and recommends that the parties at interest, lay and medical, in any community work out their problems of obtaining needed medical practitioners, while maintaining all the time honored traditions of the unrestricted private practice of medicine, be it further

RESOLVED, that the Medical Association of Georgia develop guidelines for local communities to use in obtaining needed physicians to provide adequate health care for their citizens.

REFERENCE COMMITTEE RECOMMENDATIONS —Several speakers described local incidents of conflict between hospital administrators or authorities and community physicians. Often this conflict stemmed from inadequate communication. It was suggested before the committee that hospitals are under pressure to recruit physicians—regardless of community need—so that they can keep hospital beds full. Your committee agrees with the sentiments expressed in this resolution.

Your reference committee is aware that the House of Delegates addressed itself to the matter of physician distribution in 1976 when it considered the recommendations of the Committee on Access to Health Care.

In keeping with the policy on MAG established in 1976 and intent of this resolution, your Reference Committee offers the following substitute resolution in lieu of Resolution 25-77:

Be It Resolved, that the Medical Association of Geor-

gia opposes the action of any hospital governing body which, unilaterally and without the express approval of the hospital medical staff, seeks to recruit physicians to practice in the community.

Be it further resolved, that the Medical Association of Georgia asks its Committee on Access to Health Care to continue to assist local communities in developing general guidelines to use in obtaining physicians as the needs arise.

Mr. Speaker, your reference committee recommends adoption of the substitute resolution.

HOUSE OF DELEGATES ACTION—Adopted the substitute resolution proposed by the reference committee.

RESOLUTION 13
FREEDOM OF CHOICE AND DIRECT BILLING

W. Daniel Jordan, M.D.
Medical Association of Atlanta

WHEREAS, current publicity indicates questions of fraud and rebate activities concerning payments of physician's fees, and

WHEREAS, certain third party payers encourage assignment of benefits directly to the physician, bypassing the recipient of services, and

WHEREAS, Section 6 of the AMA Code of Ethics encourages the maintenance of direct physician-patient relationship concerning medical services, therefore, be it

RESOLVED, that the House of Delegates of MAG in Annual Session declares its support for the patient's right to maintain control of the medical profession by free choice of his physician and by direct involvement in payment for his medical services, and be it further

RESOLVED, that the House of Delegates of MAG instruct its Legislative Committee to pursue legislative activity that would remove legal prohibitions of direct billing of patients, and be it further

RESOLVED, that MAG encourage all physicians in the private practice of medicine to adopt and maintain direct billing and receiving procedures in their medical practice.

REFERENCE COMMITTEE RECOMMENDATION —This resolution calls on MAG to support the patient's freedom of choice of physician, seeks to obtain legislative action to remove the legal prohibitions for direct billing, and encourages physicians to direct bill their patients.

The reference committee believes that the first resolve could be clarified by the substitution of the following:

"Be It Resolved, that the MAG House of Delegates declares its support for the patient's right of free choice of physician and method of payment, and that the AMA delegation seek similar approval from the AMA."

Mr. Speaker, your reference committee recommends adoption of this portion of the resolution as amended.

The reference committee agreed that, in the second resolve, MAG should investigate various means to eliminate any restrictions on direct billing. This could be through administrative or legislative action at federal or state levels. This goal would be better achieved by stating:

"Be It Resolved, that the MAG House of Delegates recommend to the Board of Directors of MAG that it investigate methods that would remove legal prohibitions of direct billing of patients, and to proceed with these efforts when methods are developed."

Mr. Speaker, your committee recommends adoption of the second portion of the resolution as amended.

The committee concurs with the expression of the third resolve calling on physicians to directly bill patients since this would maintain a closer relationship between physician and patient.

Mr. Speaker, your committee recommends adoption of the third portion of this resolution.

HOUSE OF DELEGATES ACTION—Adopted Resolution 13 as amended.

RESOLUTION 10
PRE-ADMISSION SCREENING

C. D. Hollis, M.D.
Dougherty County Medical Society

WHEREAS, the cost of hospital care both under Medicare and Medicaid and under private health insurance has increased rapidly, and

WHEREAS, there is increasing demand for development of some method of controlling the costs, and

WHEREAS, repeatedly the matter of some type of preadmission screening for both medical and surgical patients has been suggested by both government and private groups, and

WHEREAS, the idea of preadmission screening has in general been abhorrent to physicians, and

WHEREAS, nontheless the possibility keeps arising that some such screening will be developed, now therefore be it

RESOLVED, that the Executive Committee of the Medical Association of Georgia refer the matter of preadmission screening to an appropriate committee for study as to whether any such screening can be developed in a feasible way, and be it further

RESOLVED, that if any reasonable approach can be developed that this information be forwarded to appropriate agencies of government and private insurance executives.

REFERENCE COMMITTEE RECOMMENDATION —This resolution urges MAG to investigate pre-admission screening mechanisms to help in controlling rising hospital costs. The vast majority of the testimony heard by the committee was opposed to this resolution. The committee concludes that there would be no purpose served in conducting such a study. The committee agrees with the members who appeared before it that preadmission screening would not improve the quality of care or reduce costs.

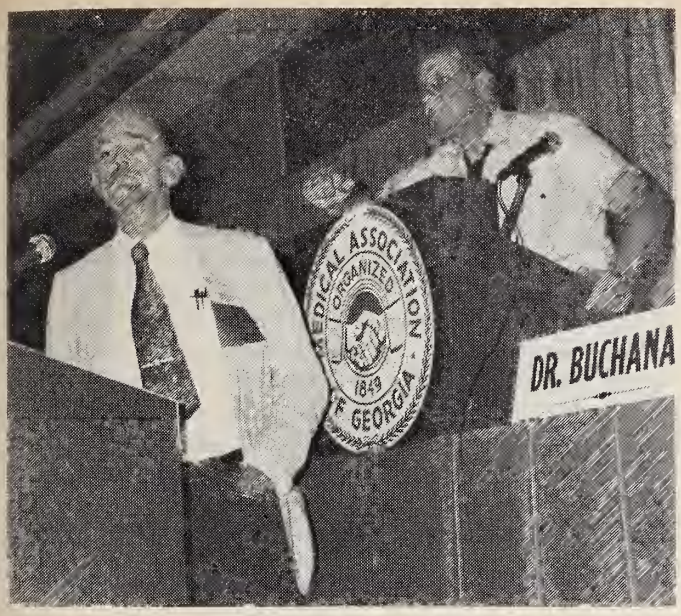
Mr. Speaker, your reference committee recommends that Resolution 10-77 be not adopted.

HOUSE OF DELEGATES ACTION—Voted that Resolution 10-77 be not adopted.

COUNCIL
MEDICARE FEE SCHEDULE (O/C6G)

Robert E. Perry Jr., M.D.

At its March meeting, the Executive Committee re-



Dr. F. W. Dowda and Speaker Buchanan

viewed a report prepared by Ralph Nader's Health Research Group and submitted to DHEW Secretary Califano. Both AMA and MAG have protested the recommendations presented in the report. The Executive Committee directed that the Council be advised of the contents of the Nader Group's report and that Council refer it to the House of Delegates. The entire report follows, for your information.

(Feb. 17, 1977: cover letter to the Secretary of the U.S. Department of Health, Education and Welfare)

Dear Mr. Califano:

Enclosed is a report we have just completed on the large and indefensible geographic variations in Medicare prevailing physician charges. We ask you to take immediate action to eliminate the billion dollars of unnecessary expenditure resulting from the uncontrolled Medicare "reasonable charge" system. Several specific suggestions are made in the report concerning reforms in the Medicare physician reimbursement system. They include the following:

1. Requesting Congress to give HEW authority to replace the "reasonable charge" system with a national Medicare fee schedule (page 23).
2. Developing such a fee schedule based on the lowest Medicare fees now being paid with adjustments only for inflation and for actual geographic differences in cost of living and differences in professional expenses (pages 23-24).
3. Requesting Congress to give HEW legislative authority to condition participation by hospitals in Medicare and Medicaid on their refusing medical staff privileges to physicians who do not accept a fair share of Medicare and Medicaid patients (to prevent large numbers of physicians from dropping public patients because of lower fees) (pages 24-25).

The last section of the report also discusses the desirability of extending such a fee schedule to all patients by incorporating it into a universal national health insurance system (page 26), which would save consumers several billion additional dollars.

We would be happy to meet with you to discuss any aspect of the report.

Sincerely,
SIDNEY M. WOLFE, M.D.
Health Research Group
Washington, D.C.

REFERENCE COMMITTEE B

HEALTH RESEARCH GROUP REPORT PRESENTED TO HEW

Title: Why Not the Most? A Physician's Guide to locating in cities with the most excessive Medicare fees in the country and an HEW guide to stopping this waste of a billion dollars. Author: Ted Bogue, Staff Associate.

INTRODUCTION

A surgeon who removed a Medicare patient's gall bladder in a hospital in Manhattan in New York City in late 1974 could have collected $1000. If the same surgeon had performed the same operation on the same patient in a hospital in Findlay, Ohio, he could have been paid a maximum of only $290. The cost of living was about 37 percent higher in New York City in 1974 than in Findlay, Ohio. The cost to the taxpayer for a Medicare gall bladder operation was about 245 percent higher.

An ophthalmologist who removed the lens of a Medicare patient's eye for cataracts in Beverly Hills could have been paid $1000 by Medicare in late 1974. Medicare would have paid the same ophthalmologist a maximum of $375 to perform the same procedure on the same patient in a hospital in rural Nebraska. The cost of living in the Los Angeles area is only about 11 percent higher than in rural Nebraska, but this operation costs about 270 percent more in Beverly Hills that in rural Nebraska.

Within New York City in late 1974 Medicare would have paid a physician a maximum of only $775 for a prostatectomy in Queens but would have paid $1220 in Manhattan, 57 percent more.

These are only a few examples of the huge geographic variations in maximum physician fees paid by the Medicare program. This report will present data on maximum physician fees paid by Medicare carriers in late 1974 and early 1975 in the 25 largest metropolitan areas for surgical procedures commonly performed on Medicare patients. While fees tend to be generally higher in metropolitan areas, there are large differences in Medicare reimbursement among and, in some cases, within these large cities. For each of the four selected procedures, the highest charge in the U.S. is more than three times the lowest, *even after adjusting for cost of living differences.* Differences of five and even ten-fold between highest and lowest areas were also found among 35 other medical procedures included in the same survey, conducted by the Social Security Admin-

istration in 1974. These ratios were reduced only slightly when the charges were adjusted for cost of living differences.

In a composite index based on the maximum allowable Medicare charges for four selected surgical procedures, these metropolitan areas (subareas within metropolitan areas have been combined and averaged for this list) had the highest Medicare prevailing charge levels *after* adjustment for cost of living differences:

Rank	*Area*	*% Above Rural Nebraska**	*% Above the National Average*
1	Los Angeles	95	52
2	San Diego	78	39
3	Orange County, California	76	37
4	San Francisco	73	35
5	Miami	72	34
6	New York City	63	27
(rural)	Kings County, California	53	19
7	Houston	51	18
8	Chicago	49	16
9	Dallas	47	15
10	Cincinnati	47	15

An alleged reason, other than cost of living differences, often cited to explain geographic variations in fee levels is large differences in malpractice insurance premiums. Malpractice costs do vary much more than the general cost of living. However, because malpractice premiums constitute only a tiny fraction of all expenses and an even smaller fraction of a physician's gross income, only a *small* increase in fees is needed to offset a *large* difference in malpractice expenses. For example, general surgeons in Los Angeles in 1974 were paying more than double the national average for malpractice premiums. However, the typical surgeon in Los Angeles could cover this additional expense by raising fees about 3 percent above the national average (after adjusting for cost of living). As shown above, Medicare fees in Los Angeles in 1974 were not 3 percent but 52 percent above the national average. A more detailed discussion of malpractice premiums is included later in this report. (See pp. 18-20.)

Though the data in this report are only for Medicare patients, unjustifiable geographic differences in fee levels and inflationary tendencies are not unique to the Medicare program. Many Medicaid state agencies and most private insurers calculate allowable fees by a method similar to that of Medicare. Thus, these problems apply to most, if not all, expenditures for physicians' services in the U.S.

American consumers are now paying a total of about $29 billion a year for physicians' services.[1] This annual expenditure amounts to about $130 per capita or about $390 per family.[2] Payments to physicians account for about 19 percent of all health care expenditures[3] and about 2.5 percent of the median family income.[4] Families pay out-of-pocket for about a third of physician services, but about two-thirds of all payments to physicians are made indirectly through third parties.[5] Taxes are used to reimburse physicians under the Medicare and Medicaid programs. Premiums are paid to Blue Shield or other insurers for coverage of major medical expenses. Employers reduce wages and/or increase prices to recover the cost of medical insurance they buy for their employees. Medicare and Medicaid alone now account for about $6 billion a year, over 20 percent of all expenditures for physicians' services.[6]

The inexplicable geographic differences in fees and the fact that a large number of physicians are already receiving fees substantially below the national average strongly suggest the need for a general reform of physician reimbursement practices which would eliminate the differences and lead to a considerable lowering of the average. Physicians in some areas would then have lower incomes but consumers and taxpayers would save billions of dollars and the quality and availability of physicians' services need not be impaired. These proposals will be discussed in more detail later in the report.

I. METHODOLOGY

The Medicare "Reasonable Charge" Physician Reimbursement System

The predominant method of compensating physicians in the U.S. is the fee-for-service system, under which a doctor is paid a fee for each service or procedure he performs. There are various methods for determining physicians' fees for a particular procedure. If the patient is paying out-of-pocket, the physician can charge whatever the "market" will bear. If the service is covered by Blue Shield or other private insurance, the fee is sometimes set by a fee schedule but more often is based on "usual and customary" charges. Medicaid programs for the poor, which are administered by the states, can use either the "usual and customary" method or a fee schedule, but Medicaid fees cannot exceed Medicare fees for the same procedure. The Federally-administered Medicare program for the elderly uses a method based on "actual," "customary," "prevailing," and "reasonable" charges, which is similar to the "usual and customary" system.

Thus, there are two general approaches, a predetermined fee schedule or a method based on what most physicians have actually been charging. The latter is more common and is the cause of the problems described in this report.

Although the statistical computations used to generate a fee by the "usual and customary" method vary from program to program, the Medicare "reasonable charge" system is typical: (1) First, the average of all "actual" fees charged by an individual doctor for a procedure, called the "customary" charge, is determined. (2) The "prevailing" charge is the charge which is below the highest 25 percent of the customary charges of all the doctors in the local area but above the lowest 75 percent; i.e., it is set *at* the 75th percentile of all customary charges. (3) The physician cannot be paid more than his customary charge or more than the prevailing charge, if it is lower than the customary charge. Whichever is lower is called the "reasonable" charge.

Under some private insurance plans and under Medicare, physicians can agree that the third party reimbursement will be payment in full for their services, i.e., that they will not attempt to collect additional payment from the patient. Under Medicare, this is

* Comparisons of high reimbursement areas with rural Nebraska may be more valid than comparisons with the national average since the latter is itself heavily influenced by the high reimbursement areas whereas the former is not.

called "accepting assignment." More than half of all Medicare doctors now refuse to accept assignment.[7] If a physician not on assignment charges a fee higher than the reasonable charge, he can collect the reasonable charge from the Medicare carrier and bill the patient for the rest.

An example may help to clarify the Medicare reasonable charge system. Suppose there are only four physicians in a particular reimbursement area who perform gall bladder operations (cholecystectomies) and each performs an equal number. Their customary (average) charges are as follows: Doctor A, $325; Doctor B, $375; Doctor C, $425; and Doctor D, $475. The prevailing charge for that area would be set at $450, higher than 75 percent of the doctors (A, B, and C) but lower than 25 percent (the other doctor, D). B could collect only $375, his customary charge, from Medicare. D could collect $450, the prevailing charge, from Medicare. He could not collect $475, his customary charge, because it is above the prevailing charge. The reasonable charge is whatever Medicare actually pays—$375 for B, $450 for D. Any of the doctors can actually *charge* more than either his customary or the prevailing charge. For example, if D were not on assignment, he could charge $500, collect $450 from Medicare, and bill the patient for $50. If D had accepted assignment, he could not bill the patient and would have to accept $450 as full payment. (His "actual" charge, for the purpose of calculating customary charges, however, is $500, not $450.)

Medicare "Prevailing Charges" as an Indication of General Physician Fee Patterns

Prevailing charges reflect what physicians in the area have actually been charging. If a significant proportion of physicians raise their fees for a particular procedure, then the prevailing charge for the subsequent year will be higher. Though prevailing charges do not reveal what individual doctors are charging in particular cases, they are statistically based on an aggregation of individual fees and therefore reflect the general level of physician fees in the area, at least for Medicare patients.

There is some evidence that the level and distribution of Medicare prevailing charges conforms fairly closely to actual fees for patients with other sources of payment. *Medical Economics* magazine conducts an annual survey of office-based physicians. In the spring of 1975 (the Medicare figures were for fiscal 1975, which ended on June 30, 1975) office-based general surgeons were asked to report their most frequent charges for several procedures.[8] Two of them, cholecystectomy and repair of inguinal hernia, are also included in this report, and a third, appendectomy, was also among the procedures on which data was collected by the Bureau of Health Insurance (as discussed below). Though the *Medical Economics* data was not limited to Medicare patients, the median, range, and distribution for all three procedures was close to those based on the Medicare prevailing charges.[9] The Medicare medians were lower in each case, but only slightly lower. Therefore, it seems likely that there is no major systematic difference between Medicare fees and non-Medicare fees. Of course, this does not mean that Medicare fees are the same as private fees in every reimbursement area.

REFERENCE COMMITTEE B

Source of Medicare Prevailing Charge Data

In 1974 the federal Bureau of Health Insurance (BHI), the branch of the Social Security Administration which administers the Medicare program, collected data from the 47 insurance carriers which serve as fiscal agents for BHI under Medicare Part B, which covers physicians' services. Each of these carriers determines a prevailing charge according to the method discussed above for each procedure and each reimbursement subarea which it establishes within its territory. There are nearly 300 such subareas in the U.S.

The BHI survey included 39 common medical and surgical procedures. The carriers were asked to report the prevailing charges for each procedure in each subarea for both general practitioners and specialists (if different prevailing charges were calculated for the two groups). Unfortunately, one of the weaknesses of the data is that different carriers can and do define specialist differently. Some use self-designation and others board-certification. However, because there are only small differences in prevailing charges between GPs and specialists in most areas, the distortion caused by varying definitions would not appear to be significant.

The Health Research Group was first alerted to the existence of the data collected in the BHI survey by an article appearing in the *New England Journal of Medicine* in May 1976.[10] The authors had made statistical computations on the prevailing charges for each of the 39 procedures included in the survey for both general practitioners and specialists. The statistics included mean (unweighted), median, standard deviation, and range. This display of data revealed wide disparities in prevailing charges from area to area but did not identify which places had which prevailing charges. Nor were any of the charges adjusted for differences in cost of living or cost of medical practice.

The Institute of Medicine (IOM) of the National Academy of Sciences, in a report on Medicare and Medicaid reimbursement policies prepared under contract with the Social Security Administration of HEW, had also used the BHI survey data, together with fee data from the Medicaid program and some commercial insurers (but not from Blue Shield, the largest private insurer).[11] IOM analyzed the impact of third party payment levels on physician choice of specialty and geographic location. All prevailing charges were adjusted for cost of living and analyzed both by individual procedure and for 32 selected counties in the U.S.[12]

We obtained the raw BHI data on prevailing Medicare charges for *all 39 procedures* in *each reimbursement area* by making a Freedom of Information Act request.

Adjustment and Presentation of Data

To illustrate the geographic variations in prevailing charges, we have selected four of the 18 surgical procedures on which charge data was collected by BHI. All four are frequently performed on both Medicare and non-Medicare patients (collectively the four accounted

for nearly 1½ million operations in the U.S. in 1973[13]) and are relatively expensive. Thus they account for a significant amount of dollar expenditure. The four procedures are cholecystectomy (removal of gall bladder), repair of inguinal hernia (rupture in the groin region), prostatectomy (removal of the prostate), and extraction of lens (removal of cataractous or opaque lens from the eye).

Prevailing charges for specialists (because general practitioners perform fewer procedures, their prevailing charges are often estimated or not established at all and thus were not used) in the 25 largest metropolitan areas (and, in some cases, subareas) in the country for these four procedures are presented in Figures 1 through 4. Each of the prevailing charges has been adjusted for the cost of living in that area. New York City, for example, has a cost of living 23 percent above the national average for urban areas.[14] A $123 charge in New York is therefore lowered to $100 so it can be compared with the charge in a city with an average cost of living (such as Los Angeles). For the same reason charges in cities with a lower than average cost of living are raised. As mentioned above, one ought to adjust for geographic differences in cost of practicing as well as in cost of living (to the extent they are different) in order to make fees exactly comparable from area to area. However, data on such costs by small geographic area are not available. Thus we are adjusting only for cost of living and assuming that the cost of practicing varies in the same way as cost of living. One expense for which this assumption does not hold, malpractice premiums, is discussed below.

For purposes of comparison, the adjusted Medicare prevailing charges for selected rural counties which are at or near the national low are also presented for each procedure. The highest prevailing charge in the country, which in each case is an area in one of the 25 cities, is also shown. The national average is the mean of adjusted prevailing charges for all the reimbursement areas in the country weighted according to the elderly population in the area.

II. DISCUSSION OF DATA

Figures 1 through 6 reveal several aspects of geographical differences in Medicare surgical specialist fees across the country and particularly in large metropolitan areas.

1. The distribution of Medicare prevailing charges *after adjustment for cost of living* for each of the four selected surgical procedures is as follows:

Figure 1—Cholecystectomy (Gall Bladder Removal): The highest prevailing charge in the nation was $813 in New York City (Manhattan), which was 1.9 times as much as the national average of $435, 3.4 times as much as the national low of $242 in Scott County, Minnesota, and as referred to earlier, 2.5 times as much as the charge of $322 in Findlay, Ohio. The five highest city areas, in order, were New York City (Manhattan)—$813, Los Angeles (Beverly Hills and the Santa Monica area)—$750, Miami—$699, Dallas—$667, and Los Angeles (Long Beach area)—$650. The national high was 2.3 times as much as the lowest charge among the 25 largest metropolitan areas, $357 in Kansas City. The highest charge in California was $750 in Los Angeles (Beverly Hills and the Santa Monica area), 50 percent higher than the lowest charge in California, $500 in Tuolumne County. The highest charge in the New York City area was $813 in Manhattan, 67 percent higher than the lowest charge in the New York City area, $488 in Nassau County.

Figure 2—Repairing Inguinal Hernia: The highest prevailing charge in the nation was $528 in New York City (Manhattan), which was 1.9 times as much as the national average of $271 and 3.7 times as much as the national low of $141 in Scott County, Minnesota. The five highest city areas, in order, were New York City (Manhattan)—$528, Los Angeles (Beverly Hills)—$500, Los Angeles (Santa Monica area)—$450, Miami—$430, and New York City (Brooklyn, Bronx, Staten Island, and Westchester County)—$407. The national high was 2.6 times as much as the lowest charge among the 25 largest metropolitan areas, $204 in Kansas City. The highest charge in California was $500 in Los Angeles (Beverly Hills), which was 57 percent higher than the lowest charge in California, $318 in Kings County. The highest charge in the New York City area was $528 in Manhattan, 62 percent higher than the lowest charge in the New York City area, $325 in Nassau County.

Figure 3—Prostatectomy: The highest prevailing charge in the nation was $1010 in Orange County, California, which was 1.7 times as much as the national average of $605 and 3.0 times as much as the charge of $333 in Hubbard County, Minnesota. The five highest city areas, in order, were Orange County, California—$1010, New York City (Manhattan)—$992, Los Angeles (Beverly Hills)—$900, Los Angeles (Torrance-Inglewood and central city areas)—$850, and Los Angeles (Long Beach area)—$840. The national high was 2.1 times as much as the lowest charge among the 25 largest metropolitan areas, $480 in Buffalo. The highest charge in California was $1010 in Orange County, 55 percent higher than the lowest charge in California, $652 in Kings County. The highest charge in the New York City area was $992 in Manhattan, 57 percent higher than the lowest charge in the New York City area, $630 in Queens.

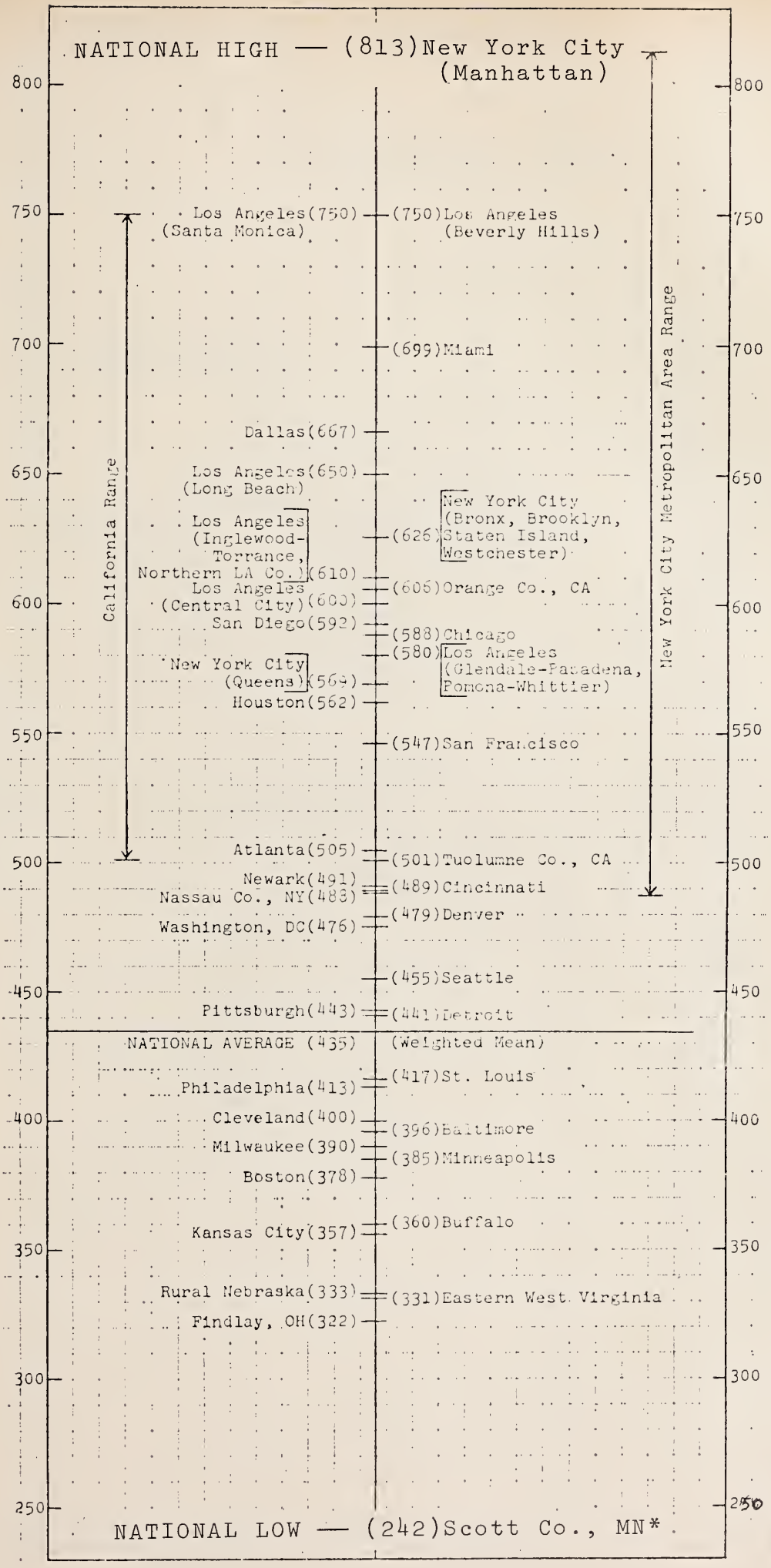
Figure 4—Extraction of Lens: The highest prevailing charge in the nation was $1000 in Los Angeles (Beverly Hills and the Santa Monica area), which was 1.9 times as much as the national average of $532, 3.1 times as much as the national low of $323 in Scott County, Minnesota, and 2.4 times as much as the charge of $417 in rural Nebraska. The five highest city areas, in order, were Los Angeles (Beverly Hills and the Santa Monica area)—$1000, Los Angeles (Glendale-Pasadena, Torrance-Inglewood, and Long Beach areas)—$800, Los Angeles (central city area)—$788, San Diego—$765, and Los Angeles (northern Los Angeles County area)—$750. The national high was 2.2 times as much as the lowest charge among the 25 largest metropolitan areas, $458 in St. Louis. The highest charge in California was $1000 in Beverly Hills and the Santa Monica area, 57 percent higher than the lowest charge in California, $636 in Kings County. The highest charge in the New York City area was $744 in Manhattan, 26 percent higher than the lowest charge in the New York City area, $536 in Nassau County.

2. *Figure 5* shows the sum of the cost-adjusted prevailing charges for all four of the procedures shown in Figures 1 through 4. For example, the total reimbursement to physicians by Medicare (after adjustment for cost of living) for one cholecystectomy, one hernia re-

FIGURE 1

MEDICARE SURGICAL SPECIALIST PREVAILING CHARGES
(DOLLARS, ADJUSTED FOR COST OF LIVING)
IN LARGEST METROPOLITAN AND SELECTED RURAL AREAS (FISCAL 1975)

Cholecystectomy

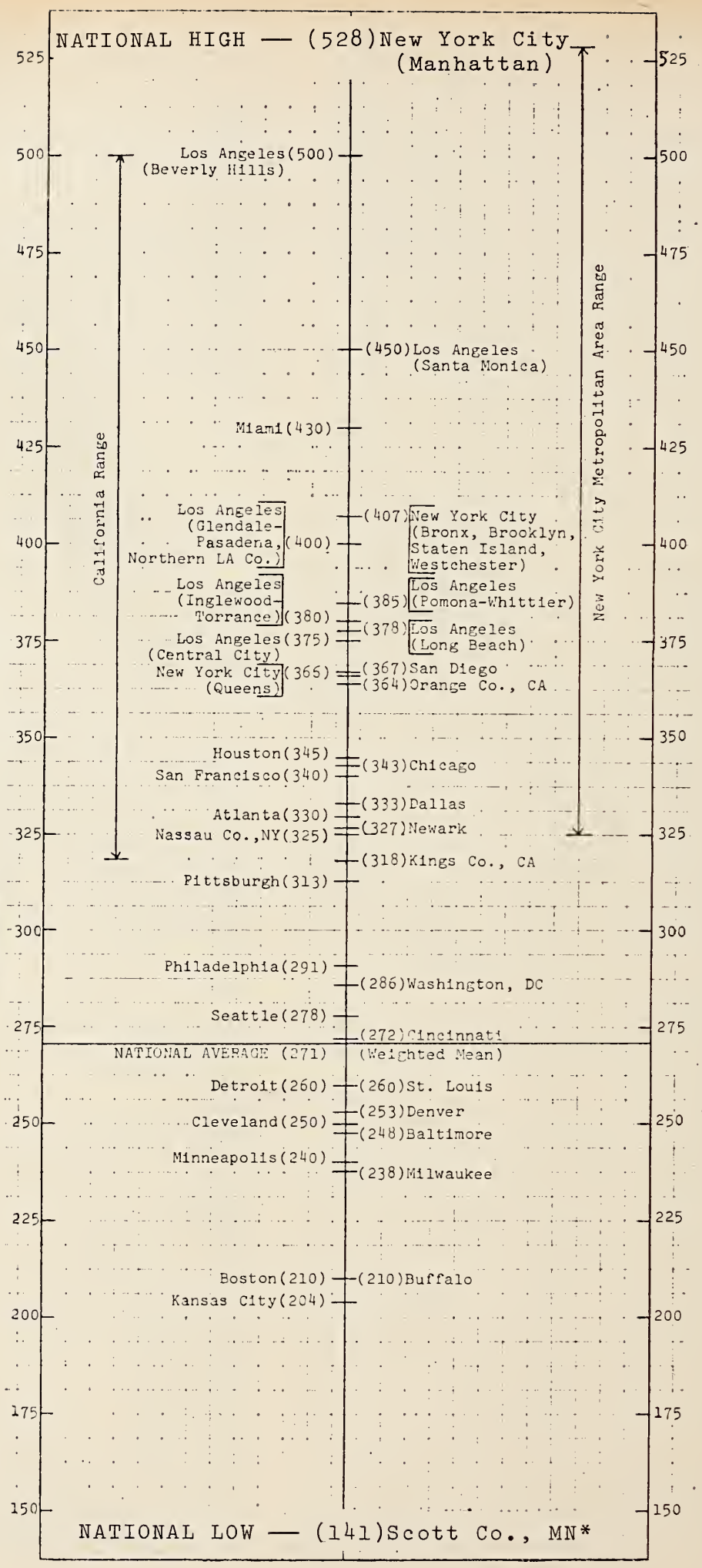


*See note after Figure 6.

FIGURE 2

MEDICARE SURGICAL SPECIALIST PREVAILING CHARGES
(DOLLARS, ADJUSTED FOR COST OF LIVING)
IN LARGEST METROPOLITAN AND SELECTED RURAL AREAS (FISCAL 1975)

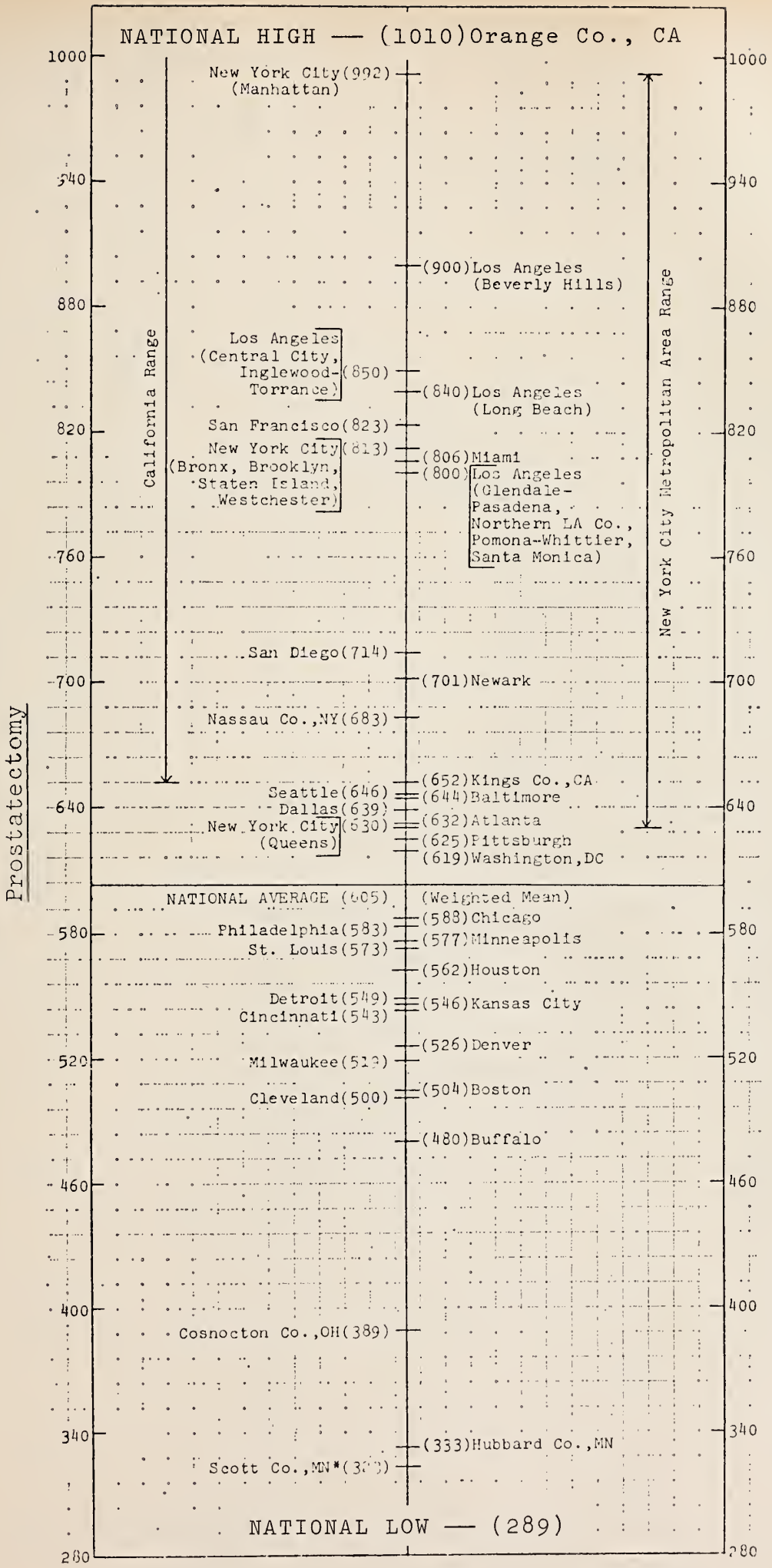
Repairing Inguinal Hernia



*See note after Figure 6.

FIGURE 3

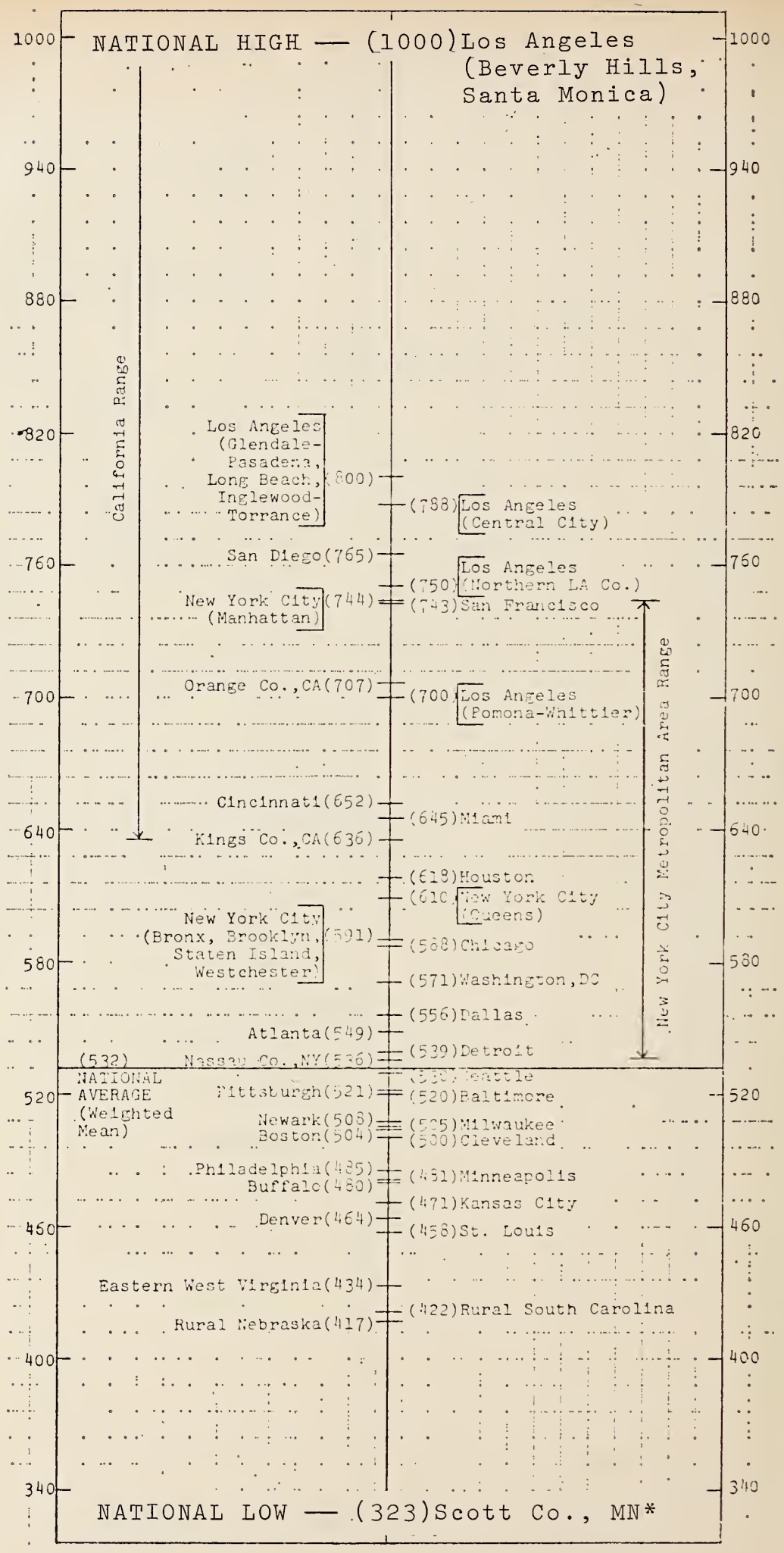
MEDICARE SURGICAL SPECIALIST PREVAILING CHARGES
(DOLLARS, ADJUSTED FOR COST OF LIVING)
IN LARGEST METROPOLITAN AND SELECTED RURAL AREAS (FISCAL 1975)



*See note after Figure 6.

FIGURE 4

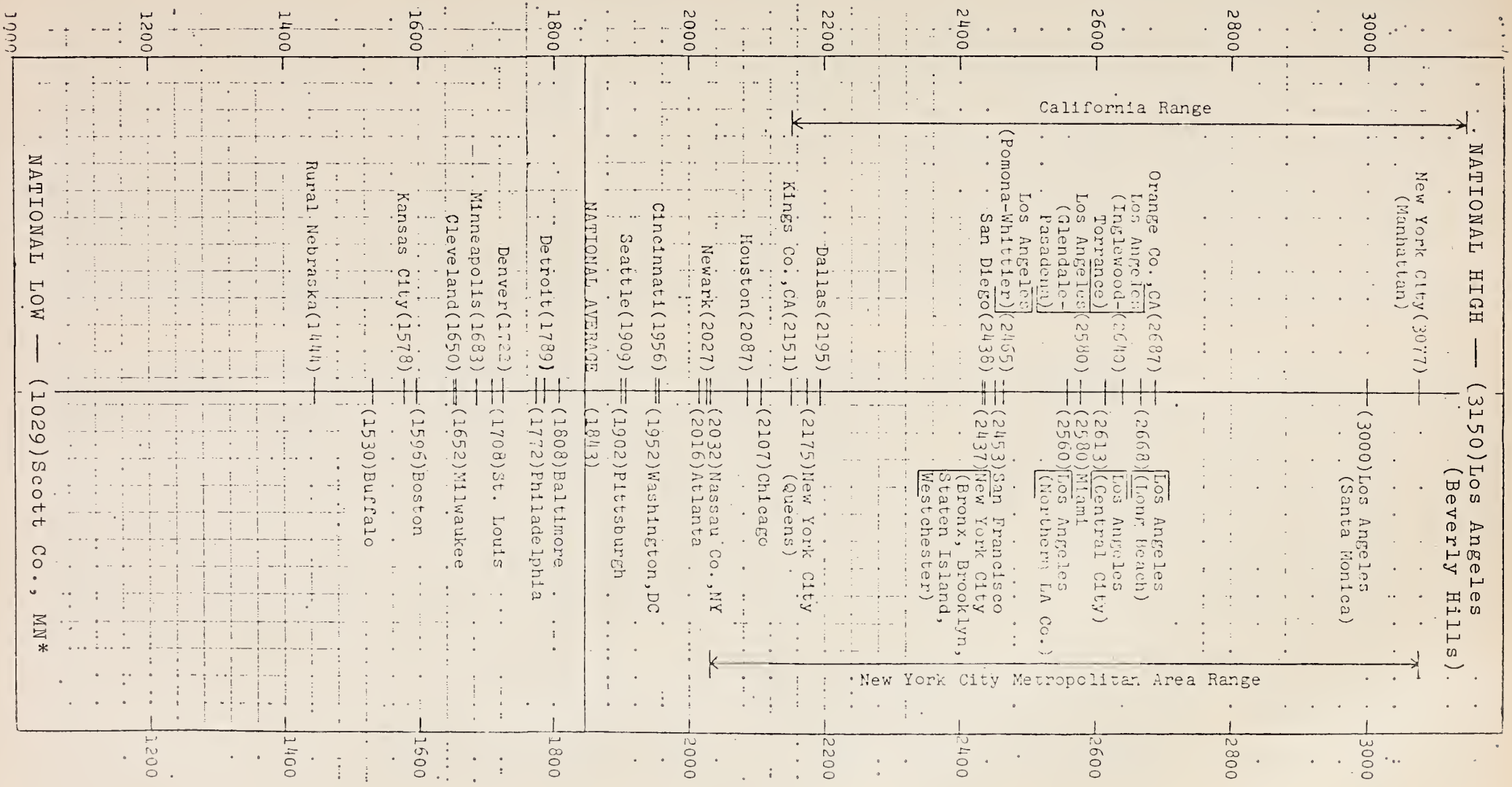
MEDICARE SURGICAL SPECIALIST PREVAILING CHARGES
(DOLLARS, ADJUSTED FOR COST OF LIVING)
IN LARGEST METROPOLITAN AND SELECTED RURAL AREAS (FISCAL 1975)



*See note after Figure 6.

FIGURE 5

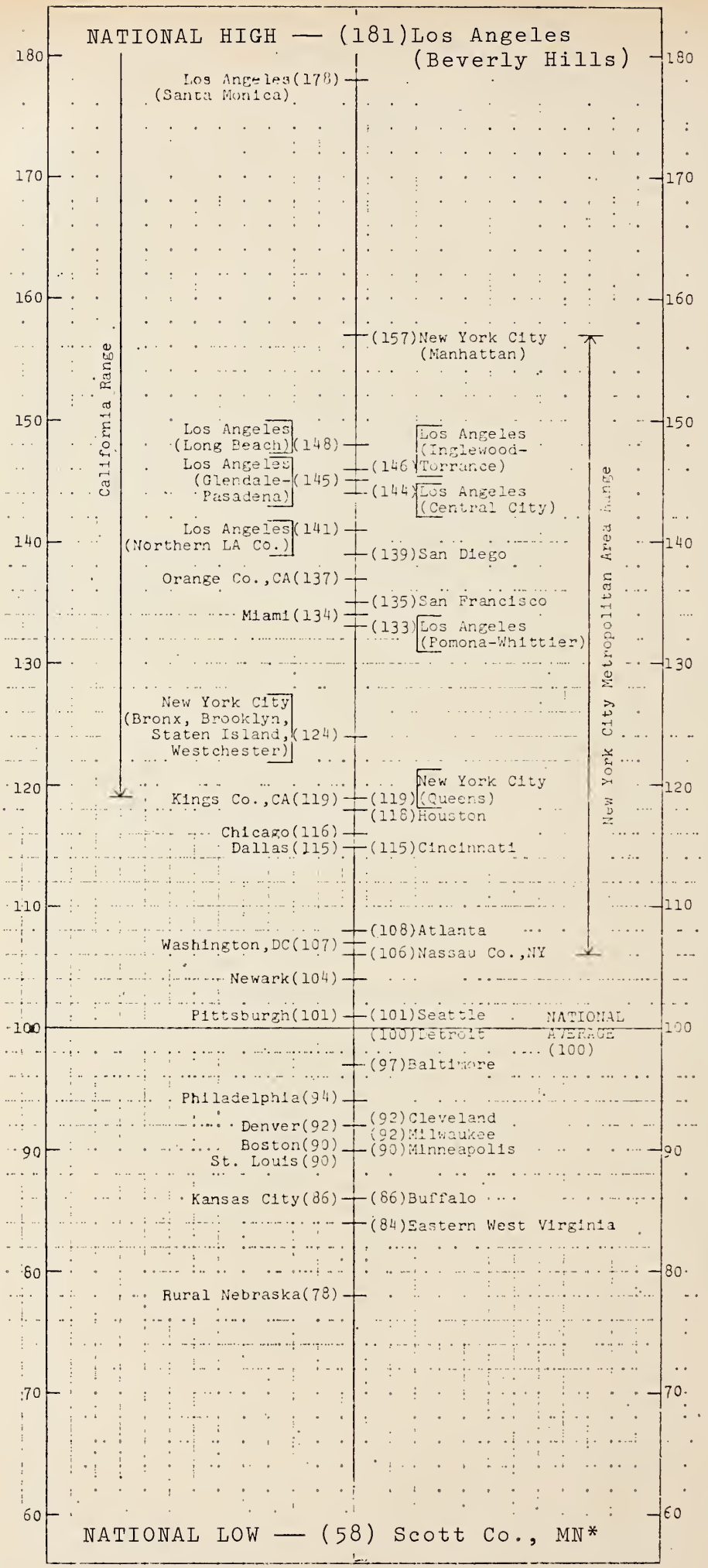
SUM (COMBINED TOTAL DOLLARS) OF MEDICARE SURGICAL SPECIALIST PREVAILING CHARGES (ADJUSTED FOR COST OF LIVING) FOR CHOLECYSTECTOMY, REPAIRING INGUINAL HERNIA, PROSTATECTOMY, AND EXTRACTION OF LENS IN LARGEST METROPOLITAN AND SELECTED RURAL AREAS (FISCAL YEAR 1975)



*See note after Figure 6.

FIGURE 6

MEDICARE SURGICAL SPECIALIST INDEX BASED ON PREVAILING CHARGES FOR CHOLECYSTECTOMY, REPAIRING INGUINAL HERNIA, PROSTATECTOMY, AND EXTRACTION OF LENS (ADJUSTED FOR COST OF LIVING) IN LARGEST METROPOLITAN AND SELECTED RURAL AREAS (FISCAL 1975)



*The prevailing charges for the reimbursement area including Scott County, Minnesota, were not based on actual and customary charges. Because of insufficient data, the prevailing charges were based on the number of "relative value" complexity units for the procedure and the number of dollars per unit chosen by the carrier.

pair, one prostatectomy, and one lens extraction in Houston was $2087. This summation of the four procedures is a relatively crude method of making comparisons among different areas because it does not weight each procedure according to its relative incidence among Medicare patients. The index figures shown in Figure 6 do incorporate such weightings and also show by what percentage an area is above or below the national average.

The highest combined charge in the nation was $3150 in Beverly Hills, which was 1.7 times as much as the national average of $1843, 3.1 times as much as the national low of $1029 in Scott County, Minnesota, and 2.2 times as much as the combined charge of $1444 in rural Nebraska. The five highest city areas, in order, were Los Angeles (Beverly Hills)—$3150, New York City (Manhattan)—$3077, Los Angeles (Santa Monica)—$3000, Orange County, California—$2687, and Los Angeles (Long Beach)—$2668. The national high was 2.1 times as much as the lowest charge among the 25 largest metropolitan areas, $1530 in Buffalo. The highest charge in California was $3150 in Beverly Hills, 46 percent higher than the lowest charge in California, $2155 in Kings County. The highest charge in the New York City area was $3077 in Manhattan, 51 percent higher than the lowest charge in the New York City area, $2032 in Nassau County.

3. *Figure 6* is a composite index which shows cost of living adjusted differences among the geographic areas for all four procedures. The index was derived as follows: The average charge for each of the four procedures (the mean of adjusted charges for all the areas in the country weighted according to the elderly population in each area)[15] was weighted according to the incidence of that procedure in a sample of all Medicare surgical procedures,[16] and a weighted mean charge among all four procedures was calculated. This charge was assigned index number 100. Charges for the four procedures in each of the reimbursement areas shown in Figures 1 through 4 were combined in the same way and compared to the national average. If the area composite charge was 20 percent higher than the national average, the area index would be 120. If it was 20 percent lower, the area index would be 80. Thus, Figure 6 reveals not only whether a particular city is above or below average but also by what percentage it varies for these four surgical procedures. The highest index, 181 in Beverly Hills, California, is more than three times as great as the lowest in the country, 58 in Scott County, Minnesota. The ratio of the highest city index to the lowest city index is more than two to one. The fifth highest city area is about 70 percent higher than the lowest city.

This index and the combined charges shown in Figure 5 reflect only Medicare prevailing charges for surgical specialists for four procedures. Therefore, the data is not necessarily representative of individual fees for all payors, all physicians, and all physician services. However, the Institute of Medicine study and the *Medical Economics* survey suggest that similar inexplicable differences exist for other payors and other procedures. Also, individual fees would, by definition, vary more than prevailing charges. In any event, it is clear that these variations cannot be explained by geographic differences in cost of living or differences in cost of doing business such as malpractice premiums (discussed below).

REFERENCE COMMITTEE B

III. CAN THE DIFFERENCES IN MEDICARE PREVAILING CHARGES BE JUSTIFIED?

There are four factors which might justify the large geographic variations in Medicare prevailing charges:

(1) Geographic differences in cost of living.

(2) Geographic differences in professional expenses, especially malpractice premiums.

(3) Differences in quality of care.

(4) Geographic differences in the balance between supply of and demand for physicians' services.

The data already presented and the following analysis, however, demonstrate that none of these factors can possibly explain more than a small percentage of the huge disparities in physician fee levels across the country. In other words, most of these variations cannot be justified even by *all* of these factors combined.

(1) *Differences in Charges Much Greater Than Cost of Living Differences*

Even after the prevailing charge data was adjusted for cost of living differences in Figures 1 through 6, the range from highest to lowest prevailing charges is extremely large. For all four of the procedures shown, the highest charge is more than three times the lowest. The range among just the large metropolitan areas shown is also large. The ratio of the highest city to the lowest city is more than two to one for each of the four procedures. Even if the highest four urban areas (the top few areas for each procedure tend to be much higher than the rest) are excluded, the ratio of the fifth highest city to the lowest city for each procedure is between 1.7 and 2.0 to one. In short, cost of living differences explain very little of the geographic variations in prevailing charges for any of the four procedures.

(2) *Differences in Malpractice Premiums Justify Only Extremely Small Differences in Fees*

As mentioned above, these prevailing charges have been adjusted for cost of living differences rather than differences in the expenses of a physician's practice. One of those expenses, malpractice insurance premiums, has often been cited by physicians as a reason for charging higher fees in areas such as California, where malpractice insurance rates are much higher.

There clearly are differences in malpractice premiums from area to area which are much greater than cost of living differences. As noted in the introduction, even the most extreme variations in malpractice rates, however, can only explain a tiny fraction of the marked geographic differences in prevailing charges. According to a *Medical Economics* survey of practice expenses in 1974, the median cost of malpractice insurance for general surgeons (most of the doctors performing the four selected procedures would be general surgeons) was $2500, or just 3.1 percent of the average general surgeon's annual gross income of about $80,000.[17] Median total practice expenses for general surgeons in 1974 were $26,140.[18] Thus, *net* income (gross income minus expenses) was about $53,860. In Los Angeles in 1974, according to the Insurance Services Office, malpractice premiums were $5107 for general surgeons, 104 percent above the national median.[19] The cost of living

index for Los Angeles in 1974 was 100, i.e., equal to the national average. In order for the Los Angeles general surgeon to still receive the national average $53,860 in *net* income despite higher malpractice premiums, his *gross* income would have to be $2607 ($5107 minus $2500) higher than average to compensate for this higher malpractice premium in California. Adding $2607 to a gross annual income of $80,000 is an increase of 3.3 percent. Therefore, because of higher malpractice premiums, a general surgeon in Los Angeles could justify fees only 3.3 percent higher than the national average. As shown in Figure 6, Medicare prevailing charges in Los Angeles for the four selected surgical procedures were not just 3.3 percent but rather 33 percent to 81 percent higher than the national average.

Differences in malpractice premiums also can obviously not explain differences in prevailing charges within a single geographic area in which the malpractice premium is constant:

All general surgeons in California covered by a particular insurance company pay the same malpractice premiums. Cost of living-adjusted prevailing Medicare charges in Beverly Hills, however, are more than 50 percent higher than those in rural California for these four surgical procedures.

All general surgeons in the New York City area pay the same amount for malpractice insurance but again the prevailing Medicare charges in Manhattan are more than 50 percent higher than those in Queens.

The ranges for California and for the New York City area are shown for each of the procedures and for the composite charges and index in Figures 5 and 6. The large range within the New York City area is also dramatic evidence of large variations in charges despite little or no difference in cost of living.

There are, of course, geographic variations in other professional expenses, such as office rental and employee salaries. However, existing data is insufficient to determine whether any of these other costs varies geographically more than cost of living, as do malpractice premiums. If not, adjusting for cost of living differences would account for them.

(3) *No Evidence of Correlation Between Price and Quality*

There is no evidence that more expensive surgery is of any better quality than less expensive surgery. Though rates of unnecessary and incompetent surgery and post-surgical mortality undoubtedly vary from surgeon to surgeon, there is no data showing a correlation between high fees and skillfully performed operations. In any event, the Medicare prevailing charge has nothing to do with quality of care but rather with the reimbursement area in which the physician happens to be practicing. The prevailing charge for all surgeons in Manhattan—good, bad, or mediocre—is exactly the same.

(4) *No Correlation Between High Fees and a Shortage of Doctors (Just the Opposite)*

In a competitive market which responds to the forces of supply and demand, an economist would predict that, because of price competition, prices (fees) would be higher in physician-shortage areas and lower in physician-surplus areas. This hypothesis was not borne out in statistical analysis performed by the Institute of Medicine.[20] In fact, the evidence points in the opposite direction. Urban areas with high densities of physicians tend to have higher fees. Other variables associated with higher fees were high concentrations of hospital beds, the presence of one or more medical schools, high per capita income in the area population, and location on the West coast.

(5) *Lack of Controls—The Real Reason for the Differences*

Since it is clear there is no legitimate reason for the geographic disparities in physician fees, one must turn to other explanations such as lack of either market or regulatory controls. In fact, the external constraints on what a physician can charge a patient for a service covered by Medicare or any other third party using a "usual and customary" payment system are minimal to non-existent. Patients usually pay only deductibles and coinsurance. Furthermore, because of lack of information[21] and alternatives, most patients do not "shop around" for physician services. Thus, physicians don't attract patients by charging low fees or drive them away by charging high fees.

The physician's financial incentive under such a system is always to charge more than both his customary charge for the previous year and the area prevailing charge. His customary charge will then stay above the prevailing charge and the next year's prevailing charge will be higher (assuming other physicians in the area behave the same way). The only limitation on increases in prevailing charges is an overall "Economic Index" which now allows prevailings for fiscal 1977 to be no more than 27.6 percent higher than fiscal 1973 prevailings. In fact, for about 70 percent of all Medicare claims, physicians charge more than the prevailing charge. The amount billed is typically 20 to 25 percent higher than the prevailing charge.

If the physician also refuses assignment and the patient can afford to pay, he can collect amounts in excess of the reasonable charge in the current year. This approach increases the physician's income at the expense of the taxpayer and sometimes the patient.

The incentives for exploiting the reimbursement system are strongest in large metropolitan areas where physicians have relatively low workloads because of the high density of physicians relative to population.[22] If a doctor wants to earn as much as he would in a more rural area, where he would have a heavier patient load, he must either perform more services per patient or charge a higher fee per service or both. The Medicare-type reimbursement system allows physicians to raise their fees with virtual certainty that the government will do nothing to stop them beyond the overall "Economic Index."

The lack of either market or regulatory constraints over Medicare fees has resulted in both rapid fee inflation (between September 1974 and September 1976 physicians' fees rose 23.3 percent while the Consumer Price Index increased 13.7 percent[23]) and completely irrational geographic differences. The situation is so absurd that it would be much cheaper for the Medicare program to pay for transportation from the high fee to the nearby low fee areas or, for that matter, to pay patients substantial rewards to have surgery done in low fee areas. For example, in Manhattan, the Medicare prevailing charge for a prostatectomy is $1220. In Queens, the prevailing charge is $775. For much less than the $445 difference, the Medicare carrier could pay for a cab or even an ambulance to take the patient

from Manhattan to Queens and still have plenty left over to give the patient a cash prize for saving the taxpayers money (perhaps a percentage of the amount saved).

Nor would such indefensible geographic differences be tolerated for federal reimbursement to those providing non-medical services to the government. For example, if the government paid transportation consultants the way it pays doctors, a consultant who would be paid $100 per day if he or she were located in Detroit would be paid about $180 per day if he or she were located in Beverly Hills for performing exactly the same service (Detroit and Beverly Hills have about the same cost of living).

IV. POLICY IMPLICATIONS

The Medicare prevailing charge data shows that physicians in many areas of the country are charging fees substantially below the national average. Even among the largest cities, which tend to have higher fees than nonmetropolitan areas, two (Buffalo and Kansas City) had fee levels 14 percent below average after adjustment for cost of living for the four procedures examined in this report. As discussed above, there is no reason why physicians in other areas should be receiving higher fees, except for adjustments for geographic differences in cost of living and in professional expenses. Given the absence of competitive market pressures on physician fee-setting, there is no justification for continuation of the Medicare reasonable charge system, which for all practical purposes allows physicians collectively to set their own fees.

Immediate Reforms in Medicare Physician Reimbursement

A Medicare fee schedule which would eliminate most of the geographic variation in charges and could save taxpayers and patients as much as a billion dollars for Medicare alone could be implemented as follows. Congressional amendment of the Medicare law would be required. The statute now ties the reasonable charge system to fees which the individual physician and other physicians in the locality have actually charged in the past. Under the alternative system, a baseline level of fees would be determined statistically from the existing national distribution of fees for each procedure.

(a) Choosing a National Baseline Level of Fees

In order to significantly reduce the total amount of physician reimbursement, a point considerably below the current national average (mean) would have to be chosen. Choosing a fee level close to the bottom of the current fee distribution, which is more than 20 percent below the national average, would save a great deal of tax money. Given that Medicare is probably now spending about $4 billion for physicians' services,[24] an overall fee reduction of 20 percent would save about 0.8 billion dollars in government spending. Since beneficiaries pay 20 percent coinsurance plus deductibles, they would save at least an additional 0.2 billion, bringing the total saved to more than $1 billion.

This figure also does not include savings in state Medicaid programs. The Medicaid law does not allow Medicaid fees to be greater than Medicare fees in any area. Though most Medicaid allowable fee levels are already substantially below Medicare prevailing charges, in some states Medicaid fees are equal or nearly equal to Medicare fees. In those states, reducing maximum Medicare charges would also reduce Medicaid fees, and additional savings would be realized.

(b) Adjusting for Geographic Differences

Having established a national standard fee level, the second step would be to adjust for geographic differences in cost of living and in professional expenses. Fee levels determine the amount of a physician's gross income, which has two components, practice expenses and net income, of which net income is much larger. When adjusting the standard fee level for a specific area, the geographic difference in cost of living must be weighted according to the proportion of gross income which is net income and the geographic difference in practice expenses must be weighted according to the proportion of gross income which is practice expenses. In this way physicians in different areas with the same volume and mix of procedures and the same efficiency of operation would earn net incomes with the same purchasing power. To compute the fees, the government would need uniform national data broken down by geographic area and by specialty on cost of living and practice expenses. Medicare would also have to periodically adjust fees for inflation in both components.

(c) Changing Only Medicare Fees Discourages Acceptance of Medicare Patients—Participation By Doctors Must Be Required

Reducing Medicare and Medicaid fees without also changing private fee levels, however, could have serious adverse effects on beneficiaries of these programs. First, physicians would have a much greater financial incentive to refuse Medicare assignment so they could compensate for lower Medicare reimbursement by charging the patient. This result could be avoided by amending the Medicare law to require mandatory assignment (as is already the case for Medicaid).

Physicians also would have a greater economic incentive to refuse to see some or all Medicare and Medicaid patients. (Such refusal is already a problem in state Medicaid programs, especially where Medicaid fees are low.) This could be remedied, however, by requiring all hospitals receiving any reimbursement from Medicare of Medicaid (and perhaps also any Hill-Burton construction funds or other federal grants) to give medical staff admitting privileges only to physicians who accepted their fair share of Medicare and Medicaid patients. Since very few communities have hospitals which accept no Medicare or Medicaid patients, most physicians would have to accept public patients in order to admit any patients to a hospital. Such a requirement would create some pressure for hospitals to drop out of Medicare and Medicaid (or perhaps for doctors to build new hospitals that admit no public patients) but very few hospitals could survive financially without any such federal money.

An alternative approach to the problem of refusal to participate in Medicare and Medicaid would be for states to require all doctors to accept Medicare and Medicaid patients as a condition of licensure. Federal Medicaid funds could be conditioned on the state's having such a provision in its medical licensure statute.

Many states already require physicians to accept all emergency patients.

Long-Term Change in Reimbursement for All Physician Services

Changing the physician reimbursement system for Medicare without changing fee levels paid by other payors, however, is unsatisfactory. In addition to the problems discussed above, controlling only Medicare fees will not achieve a substantial percentage reduction in total national expenditures for physician services. Payments by private insurers and self-payment, which account for about 80 percent of physician reimbursement, wouldn't be affected.

(a) State Regulation Versus National Health Insurance

Until there is a universal national financing system, the only way to achieve uniformity among all public and private payors is by state legislation. Adherence to a publicly determined fee schedule for all patients, public and private, could be made a condition of licensure by the state. Some states, such as Maryland and Massachusetts, are already setting all rates, both public and private, for health facilities. Of course, there is no assurance that all states would adopt a fee schedule, or, if they did, that it would be set at the same level. However, with a national health insurance system which covered all patients and all physician services, it would be possible to have both geographic uniformity and control over all expenditures for physicians' services.

With a centrally regulated payment system, much more significant savings could be realized. An overall 20 percent reduction in the total national bill for physicians services of about $29 billion a year would save $5.8 billion a year, or nearly $80 per family per year.

Spending the extra billions of dollars now serves only to support a higher standard of living for physicians in high fee areas, since there is no evidence that the additional money buys any better or more accessible physician services. In other words, the only effect of the current physician reimbursement system is to redistribute income from consumers and taxpayers to doctors, i.e., from the poorer to the richer.

(b) Problems Arising From Lower Fees

Even if a uniform national fee schedule could be successfully implemented, however, other serious difficulties might arise.

1. Problems Inherent in the Fee-for-Service System —The Need for Alternatives

First, any fee-for-service system contains a financial incentive for higher utilization, i.e., given a fixed fee for any service, a doctor maximizes his income by maximizing the number of services he delivers. For most services (initial office visits would be an exception), the physician rather than the patient decides whether the service will be performed. In prepaid health maintenance organizations where these incentives are absent or reversed, rates of surgery are typically half as great.[25]

If third parties substantially lower physician fees but continue to pay on a fee-for-service basis, doctors will have a powerful incentive to increase the volume of services they deliver to compensate for the lower fees. Such an increase in utilization of physicians services might largely or completely eliminate the savings which one would expect from lower fees.[26] There is also a greater likelihood that the additional marginal services performed would be unnecessary, which would mean subjecting more patients to unnecessary risks or even death, especially for surgical operations.

Therefore, if the fee-for-service reimbursement system is continued, the reduction of fees must be accompanied by stricter controls to prevent unnecessary utilization.

In the long run, the only way of effectively controlling the total cost of physician services may be to pay doctors on a capitation (per person) basis for providing comprehensive physician services to patients. Then the doctor's financial incentive will be to maximize the number of patients he sees and minimize the cost of services provided to each patient. Controls would be necessary to assure that doctors do not fail to provide necessary services. Such a payment system would be similar to prepaid group practices or health maintenance organizations, except that only physicians' services would be covered. Another alternative is to pay physicians salaries, as do many HMOs.

2. Financial Incentives for Higher Quality Care— The Lack of Data

It also might be argued that some physicians should be paid more than others for performing a particular procedure because they are better trained, more experienced, or more skillful. An ideal reimbursement system ought to provide incentives for higher quality care. However, as discussed above, there is currently no evidence that more expensive surgery is any better quality than less expensive surgery.

Until we develop objective assessments of the competence of individual physicians, there is no way to financially reward high quality with high fees.

3. Reducing Doctors' Incomes Not a Serious Problem

Reducing the level of physician reimbursement (to the extent lower fees are not offset by more services) would decrease the income and the standard of living of most physicians. Though such action will clearly be financially detrimental to most physicians, consumers would probably not suffer from reductions in either quality or quantity of medical services. Only if physician compensation falls so low that an insufficient number of people want to enter the medical profession would the supply of physicians decline. An across-the-board cut of 20 percent in physician fees would reduce average physician income from about $60,000 per year to about $40,000 per year[27] which is still almost three times the median family income in the U.S.[28] Given the great surplus of young people who now apply to enter medical school, only a more drastic cut in physician income is likely to make medicine so unattractive that the number of people entering the field will decline.

CONCLUSION

This report has presented data which shows the existence of extremely large and unjustifiable geographic differences in Medicare prevailing charges for physicians. After analysis, it is quite clear that these variations do not reflect differences in cost of living, in malpractice premiums, in other professional expenses, in quality of care, or in demand and supply. In fact, they appear to result from a payment system which allows physicians in local reimbursement areas to substantially determine their own fees without regard to any of

these factors. Thus the system both preserves completely arbitrary regional differences which pre-existed Medicare and contains an inherent inflationary bias.

Possible remedies, ranging from changing only the Medicare reimbursement system to establishing a uniform national fee schedule to abolishing the fee-for-service system, have been discussed. The critical issue is whether the government and other third party payors are willing to undertake obviously needed reform which will benefit consumers and taxpayers at the financial expense of many members of the medical profession.

REFERENCES

1. In fiscal 1976, national expenditures for physicians' services were $26.4 billion. U.S. Department of H.E.W., Social Security Administration, Office of Research and Statistics, "National Health Expenditures, Fiscal Year 1976," Research and Statistics Note No. 27, December 22, 1976. The estimate of $29 billion for fiscal 1977, now more than half completed, assumes a 10 percent increase in expenditures over fiscal 1976. Annual increases for the two preceding years were 15 percent and 16 percent. *Id.* at 3.
2. Based on most recent population estimates from the U.S. Bureau of the Census.
3. U.S. Dept. of H.E.W., *supra* note 1, at 3.
4. Based on 110 percent of median family income for 1975 as reported by the U.S. Bureau of the Census.
5. Mueller and Gibson, "National Health Expenditures, Fiscal Year 1975," 39 *Social Security Bulletin* #2, at 18 (February 1976).
6. *Id.* at 7-10. Though the figure for fiscal 1976 is only $5.3 billion, Medicare and Medicaid spending on physician services is likely to have increased to at least $6 billion by fiscal 1977.
7. Institute of Medicine, National Academy of Sciences, *Medicare-Medicaid Reimbursement Policies,* ch. 10, at 17 (March 1976).
8. Owens, "At Last: Hard Figures on How Fast Fees Have Been Climbing," *Medical Economics,* October 13, 1975, at 113.
9. Medians were calculated for the Medicare data in Schieber, Burney, Golden, and Knaus, "Physician Fee Patterns Under Medicare: A Descriptive Analysis," 294 *New Eng. J. Med.* 1089, 1090 (May 13, 1976).
10. *Id.*
11. Institute of Medicine, *supra* note 7, ch. 10.
12. *Id.* at 8-16.
13. National Center for Health Statistics, U.S. Department of H.E.W., Surgical Operations in Short-Stay Hospitals: United States—1973, at 9 (May 1976).
14. Cost of living figures were obtained from the U.S. Department of Labor Bureau of Labor Statistics' comparative indexes for a high budget 4-person family in autumn 1974. The New York City index was used for Nassau County, New York. Index figures for Newark, Miami, and Orange County, California, were obtained from those generated by the Institute of Medicine for metropolitan areas not included in the BLS data.
15. Institute of Medicine, *supra* note 7, ch. 10, at 9. The average for prostatectomy, which had been calculated but not published, was obtained from one of the authors of the IOM study.
16. Incidence figures were obtained from a 20 percent sample of Medicare short-stay hospital discharges in calendar year 1973 done by the Office of Research and Statistics of the Social Security Administration.
17. Owens, "Holding Down Professional Costs: Latest Figures on Nine Specialties," *Medical Economics,* December 8, 1975, at 144, 152.
18. *Id.* at 145.
19. "A State by State Look at Malpractice Premiums," *Resident and Staff Physician,* April 1974, at 25, 26.
20. Institute of Medicine, *supra* note 7, ch. 10, at 13-14.
21. The amount of comparative information on physicians, though still grossly inadequate, is increasing. More than 20 local groups have now published doctor directories.
22. According to a telephone survey conducted by Mathematica, Inc., physicians in low fee rural and small metropolitan areas saw, respectively, 27 and 16 percent more office patients per week, 185 and 143 percent more hospital patients per week, and 22 and 14 percent more patients per hour than physicians in high fee large metropolitan areas. C. Berry, R. Feiden, P. J. Held, and J. Wooldridge, *Abstract from Report on the Physician Capacity Utilization Telephone Surveys* 5-8 (May 1976) (unpublished paper, Princeton: Mathematica, Inc.).
23. Calculated from *CPI Detailed Reports,* U.S. Department of Labor Bureau of Labor Statistics.
24. In fiscal year 1976 Medicare spent about $3.5 billion for physicians' services. Unpublished statistics from Social Security Administration Office of Research and Statistics. 4.0 billion assumes an increase of about 14 percent from fiscal 1976 to fiscal 1977 (less than any of the last 3 annual increases).
25. Gaus, Cooper and Hirschman, "Contrasts in HMO and Fee-for-Service Performance," 39 *Social Security Bulletin,* May 1976, at 3, 9.
26. It appears that this phenomenon explains large increases in spending for physician services even after introduction of negotiated fee schedules in the Canadian National Health Insurance program. Lewin and Associates, Inc., *Government Controls on the Health Care System: The Canadian Experience* 9-10, 14 (Jan. 1976).
27. See Owens, "Earnings Survey: Which Specialties Are Staying Ahead of Inflation?" *Medical Economics,* Oct. 18, 1976, at 146-58. This estimate assumes a gross income of $100,000 before reductions.
28. See note 4 *supra.*

REFERENCE COMMITTEE B

REFERENCE COMMITTEE RECOMMENDATION—This report from Council provided the delegates with an opportunity to read a Nader report on Medicare fees across the country and his group's recommendations based on its findings. The report includes recommendations to the Department of HEW on establishing a national fee schedule based on the lowest Medicare fees and tying in of medical staff privileges to physician acceptance of medicare and medicaid patients.

No proponents of this report spoke to the reference committee. The reference committee concurs with those who spoke against it in their condemnation of this report. The committee is aware of AMA's protests delivered to DHEW and MAG's protest sent to the Georgia Congressional delegation. In order to further disseminate this report and to solicit additional protests, the committee makes the following recommendations:

1. Report O/C6G should be filed.

2. Copies of the Nader report should be suitably (to attract the greatest possible attention) printed and distributed to all MAG members.

3. All members should be encouraged to express their views on the report and to protest its recommendations to the Secretary of HEW and to the Georgia Congressional delegation.

Mr. Speaker, your reference committee recommends adoption of those recommendations.

HOUSE OF DELEGATES ACTION—The House adopted three recommendations: (1) Voted to file Report O/C6G; (2) Voted to have this Report printed and distributed to all MAG members, and (3) Voted to encourage all members to express their views on this Report and to protest this Recommendation to the Secretary of HEW and to the Georgia Congressional Delegation.

COMMITTEE ON NURSING (C36)

J. H. Rhodes Haverty, M.D.

The Committee on Nursing of the MAG met on March 8, 1977, and all members were present. We met in response to a motion passed by the Executive Committee asking for our recommendations on the Nurse Practice Act and "the matter of where nursing stops and the practice of medicine begins."

Considerable discussion took place among the members, with recollection of similar discussions that have taken place in this committee over the past several years. It was recognized that we were not capable of coming up with an extensive list of what constitutes the practice of medicine vis-á-vis the practice of nursing. With further deliberation, we felt that the practice acts themselves were sufficient in establishing appropriate boundaries for these two professional groups.

The Medical Practice Act is an unlimited practice act, and, therefore, any provision of health care is clearly within the province of the practice of medicine.

The Nurse Practice Act states, "Practice of nursing as a registered professional nurse means the perform-

ance for compensation of any act in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the administration of medications and medical treatments as prescribed by a physician practicing medicine in accordance with the provisions of Code Chapter 84-9." In the opinion of the committee, this clearly puts the administration of medications and medical treatments under the prescription or direction of a physician and clearly limits a nurse from performing such functions when she is not under the direction or prescription of a physician.

It might be recalled that the MAG had considerable input into the wording of the Nurse Practice Act which was passed in 1975. More liberal interpretations of an earlier draft of the Nurse Practice Act were eliminated by the medical profession, and the MAG gave its seal of approval to the revised Practice Act. The committee feels that this is an appropriate practice act and that it clearly limits medical functions practiced by a nurse.

It should be readily recognized by those concerned about these issues that the construction of a "laundry list" of allowable or prohibited functions by a nurse would run the risk of going too far for some and not far enough for others, and of omitting important considerations. The committee feels that the wording of the practice act itself, while broad, clearly limits the practice of nursing as it relates to medical functions.

Where differences of opinion occur, the individual situation must be judged on its own merits, properly in a court of law. Whether a nurse is illegally practicing medicine, or is extending the bounds of her own practice act, should be determined with the advice and counsel of the two respective boards, and by appropriate adjudication of the matter itself. It is certainly true that medical and nursing functions are overlapping, and in some situations what is done by a physician may be understood to be the practice of medicine and the same function performed by a nurse may be the practice of nursing. The taking of a blood pressure is a good example of this kind of overlapping function.

A related issue which causes considerable concern is that of the functions of "nurse practitioners." It should be pointed out that there is presently no organized national group of nurse practitioners recognized by this title and, indeed, there is no generally accepted definition of a nurse practitioner. Individuals who classify themselves as "nurse practitioners" or "registered nurse practitioners" or other similar descriptions obviously may do so as long as there are no legal prohibitions against it. Nevertheless, since there is no legal certification for nurse practitioners, such a title may mislead the public, the medical profession, and others.

RECOMMENDATION

Whereas, The Nurse Practice Act for Georgia already spells out the limitations of the practice of nursing and has the support of organized medicine in Georgia, therefore this Committee recommended that:

1. MAG affirm its support of the Nurse Practice Act, and that

2. MAG support a policy that individual situations involving the alleged practice of medicine by nurses should be settled on their own merit, based on the appropriate interpretation of the specific practice act, and that

3. this policy be communicated to the Composite State Board of Medical Examiners and the Board of Nursing.

REFERENCE COMMITTEE RECOMMENDATION —This report reviews the definition of nursing as contained in the Nurse Practice Act, explains the problem area where nursing and medicine meet, and explains the status of nurse practitioners. Some of the testimony before the Committee reflected a desire to restrict nurse practice further than the Act currently does. It was pointed out during the hearing that the Nurse Practice Act is quite clear in requiring physician direction of nurses.

Recommendation 1 affirms MAG support of the current Nurse Practice Act. Recommendation 2 suggests that individual situations of nurses allegedly practicing medicine be settled on their own merits.

Recommendation 3 asks that the MAG policy be communicated to the state boards for nurses and physicians.

The reference committee was in agreement with these recommendations. However, since MAG previously supported the Nurse Practice Act, technically we now should reaffirm our support. Further, the Committee believe that any questionable practices by a nurse should be reported and resolved by whatever legal entity has such a responsibility. Therefore, to accomplish these ends the reference committee proposes the following substitute recommendation in lieu of those in the report:

"MAG reaffirms its support for the Nurse Practice Act and encourages its members to report any suspected violations to the appropriate authorities."

Mr. Speaker, your reference committee recommends adoption of the reference committee's substitute.

HOUSE OF DELEGATES ACTION—Adopted the substitute Recommendation made by the reference committee in lieu of those contained in the committee report.

COMMITTEE ON PHYSICIAN ASSISTANTS MAJORITY REPORT (C40a)

Leon E. Curry, M.D., Vice-Chairman

In 1974 the MAG House of Delegates formed an Ad Hoc Committee on Physician Assistants in order to investigate this new paramedical field. Its first report, in 1976, along with a review of the report done for MAG Council, was referred to Reference Committee D of the 1976 House of Delegates.

At the reference committee hearing, there was considerable testimony which identified hitherto unreported problems with physician assistants. The actual and potential problems centered upon several areas:

1. Abuse of PAs by physicians in private practice who do not properly monitor their activities. None have so far required any serious disciplinary action by the Composite Board of Medical Examiners (see Exhibit A).

2. Distortion of the PA concept by governmental agencies such that a Physician Assistant is used to render medical care *instead of* a physician, rather than *under supervision of* a physician.

3. Efforts by PAs to achieve greater autonomy via independent licensing, national organizations, etc.

There is as yet no evidence of such activity in Georgia.

Evidence has been given to the committee that PAs used by physicians in private practice, properly supervised, can improve the physicians' practice, freeing them from some of the routine duties and allowing them more time for their patients.

The advantages cited by those physicians employing PAs include the following:

1. Allows physician more time for complicated patients
2. Allows physician to serve larger patient population
3. Allows physician to create more complete data base and thus to provide more accurate diagnosis and treatment
4. Allows physician to provide more services to patient population by delegation of certain time-consuming procedures to PAs.
5. Diminishes patient waiting time in physician's office.

The Committee on Physician Assistants has met three times this year, and, in essence, its meetings have served to examine and debate the testimony presented to the reference committee as well as subsequent information brought to the committee.

Evidence has come before the committee concerning the problems related to PAs, including:

Newspaper articles and other testimony concerning misuse of PAs by physicians in private practice.

Items from several sources showing state and federal government and military have a keen interest in the PA concept, and these may present potential problems in the future.

1. *American Medical News 8/76*—reported a grant from HEW of $722,090 to the American Academy of Physicians Assistants, to study experimental approaches to the use of *indirectly* supervised PAs.
2. *Congressional Record 3/1/77*—reported the planned use of physician extenders instead of physicians to provide "the same high quality care."
3. HSA Task Force guidelines suggest that physician extenders may be used to render primary care under protocols with supervision by physicians in an *indirect* manner.
4. A letter from Col. Anton Hitzelberger to the committee in which he states that the PAs have "essentially taken over the duties of the General Medical Officer or Battalion Surgeon."
5. Items in the press show that in New Jersey the Medical Society is in opposition to S.B. 1354 which would allow Physician Assistants to function *without* physician supervision.

Another area of expressed concern is the nurse practitioner who is allowed by law to practice independently of physician supervision. This, however, is not under the purview of this committee and indeed is a separate problem regulated under a different act of the Georgia Legislature.

RECOMMENDATIONS

In view of this testimony, the committee recommends that the following action be taken by the House of Delegates:

1. Recommend legislation to assure that:
   A. PAs certified by the Composite Board of Medical Examiners be required to fulfill the Georgia Association of Physicians Assistants requirements of continuing medical education (100 hours every two years); and
   B. potential abuses of PAs by physicians in the private sector (e.g., in satellite clinics, emergency room care, etc.) be closely monitored by the Composite Board of Medical Examiners.
2. Pass a Resolution that the Medical Association of Georgia opposes independent licensure of PAs by the State of Georgia.
3. In the area of governmental distortion of the PA concept, the following steps be taken:
   A. Instruct our AMA Delegation to present evidence of governmental distortion of the PA concept at the next AMA National Meeting.
   B. Provide our Congressional Delegation with the same information.
   C. Alert our physician members who serve on governmental liaison committees such as HSA, DHR, etc., of the same problem.
4. Continue to press for a requirement that all government agencies require direct physician supervision of all PA services.
5. MAG should support the PA concept by:
   A. promoting and protecting the proper utilization of PAs in Georgia;
   B. endorsing the Georgia Association of Physicians' Assistants as the professional organization for PAs in Georgia;
   C. assisting PAs in their efforts at continuing medical education;
   D. doing all within its means to assure that PAs remain in our camp as our friends and allies as well as our assistants; and
   E. assisting the Composite Board in its activities of monitoring PAs.
6. MAG should support and endorse the Georgia Association of Physicians' Assistants' efforts to:
   A. endorse the National P.A. Certification Exam, encourage the development of specialty add-ons for said examination, and require Georgia PAs to pass;
   B. endorse the requirement of continuing education in order to maintain PA certification in Georgia;
   C. endorse the concept that all physician "extenders" (PA, nurse practitioner, Medex, etc.) must be employed and supervised by a physician;
   D. endorse the proper utilization of physician assistants;
   E. investigate further the differences between the roles of physician assistants, nurse practitioners, and other health professionals; and
   F. encourage open discussion at PA Committee meetings relative to alleged PA abuses (by physicians and PAs).

REFERENCE COMMITTEE B

EXHIBIT A

Information Supplied by Georgia Association of Physicians' Assistants

Only 35 complaints have come before the Composite Board related to paramedical personnel:

11—no investigation necessary (failed to notify address change, etc.)
21 investigations
5—no violations found
6—working as PA *prior* to certification
5—found in violation and reprimanded (2 of these were foreign medical graduates, and 2 complaints were originated by PAs)
1—practicing medicine—this person quit during the application process
4—"open" investigations
1—prescription abuse
1—foreign medical graduate
2—nurse practitioners
3—not individual PA accusations
2—against *program* abuses—investigation tabled
1—FMG—"tabled" prior to investigation

Findings of Investigations by the Composite Board of Medical Examiners

A. There have been no PA prosecutions, revocations, or certificate denials to date.

B. Only one legal hearing has been held by the Board (reprimanded)

C. Of the 21 investigations, 14 concerned PAs temporarily certified and 7 concerned PAs permanently certified.

D. Five FMGs were accused of "practicing medicine" while being certified as PAs.

E. Two complaints were against nurse practitioners. (Previously five investigations of nurse practitioners had come before the *Nursing* Board.)

COMMITTEE ON PHYSICIAN ASSISTANTS MINORITY REPORT (C406)

Milton I. Johnson, M.D.

The Majority Report of the committee is acceptable to the writer through #4 under "RECOMMENDATIONS." From that point forward, it does not address the charge given to the committee to "look into the actual and potential problems that exist in the development of the PA profession."

I would beg the indulgence of the reference committee and the House of Delegates to give some comments at this time.

We have used "physicians' assistants" in the practice of medicine since time immemorial. There is no doubt that any intelligent person can be trained to do this work.

The real question before us is, should we nurture an additional formalized paramedical group?

Let me state for the record that I have no vested interest in the concept of physicians' assistants since I neither train nor employ them.

The Chairman of Council last year assigned me to review and comment on a Committee Report on this subject. At that time I tried to learn something about PAs and the implications thereof. Some of the discoveries were alarming to me and I so reported.

There was nothing in my report to Council that advocated doing away with those PAs presently certified, and indeed, a year later, I STILL FEEL THAT THOSE PRESENTLY CERTIFIED SHOULD BE LEFT UNDISTURBED.

There are presently 146 "graduate" physicians' assistants in Georgia and 128 "grandfather clause" PAs. Many of the former are employed in hospitals as technicians, most of the latter are people who have been employed as assistants by private physicians for many years.

There are 6200 (approximately) licensed physicians residing in the State of Georgia. There are 4348 members of MAG. Thus only a miniscule percentage of our physicians have chosen to use graduate physicians' assistants in their practice.

It is my understanding that most of the "grandfather" group is not likely to continue to be certified because of the type of recertification examination that is being proposed.

This is in spite of the fact that many of these people have years of experience under guidance of their physician-employers and, indeed, there are many with much more formal training than the "graduate" PAs.

Fortunately, if the above situation materializes, the "grandfather-clause" PAs will not really be affected because they will be as secure in their jobs as ever, and their duties and remuneration will not likely change.

If you will be so kind as to indulge me further, I am constrained to correct the third paragraph of the open letter dated March 21, 1977, sent out across the state by Dr. Robert H. Curry, the Director of the Physicians' Associate Program at Emory University. (See Exhibit 1 which follows.)

Dr. Johnson *did not seek* to make the last year's report on the PA Committee's Report, *did not seek to publish this report, has not written any form letters,* and *has not attempted to dominate any meetings, or to serve on any committees.* As a matter of fact, there has been only *one* reference committee meeting on this subject. Dr. Robert H. Curry was not in attendance at the meeting, and, indeed, did not see fit to join his state medical society (MAG) until October 4, 1976.

Furthermore, it is obvious from the makeup of this year's Ad Hoc Committee that I did not influence its composition (nor did I try to do so). The committee is composed of the three PA Training Program Directors in this state and physicians who employ physicians' assistants (9 of 12 members to my knowledge), and the Secretary of the Georgia Association of Physicians' Assistants as "liaison."

Last year the Chairman and members of the reference committee recognized everyone, to my recollection, who wished the floor, some of them more than once.

Thank you for letting me set the record straight.

The federal government is right on schedule as projected. A "physician extender reimbursement study" has been announced by the Social Security Administration. I would respectfully commend study of the "Executive Summary" (see Exhibit 2) especially paragraph 2 on page 2 and paragraph 3 on page 3.

The guidelines are out now (see Exhibit 3 of March 1977), and "eligible" practices will be reimbursed at one of four rates for medicare-covered services delivered by a PA. Practices choosing to participate will be ASSIGNED one of the following rates:

1. 100% of the supervising physician's maximum allowable charge
2. 80% of the supervising physician's maximum allowable charge
3. 62% of the supervising physician's maximum allowable charge (or Cost, whichever is greater)

4. a "lump sum" cost related rate.

I leave it to your good judgment as to which one will eventually be assigned for *all physicians.*

It is easy to project that under "National Health Insurance," protocols may dictate how many times a physician may see his patient and thereafter have him seen by a graduate PA. Cost control is the name of the game and will override considerations of quality as it does under the British Medical System. Of course, one may reasonably assume that the physician may see his patient anyway at the fee level of the physician's assistant.

Those physicians in primary care (family practitioners, pediatricians, internists and obstetricians) are the most vulnerable at the onset in possible government decreed use of physicians' assistants in lieu of physicians. There is incontrovertible evidence that this is already being done in the armed services.

As long as government money is available to finance these training programs, they will continue.

In view of all the evidence as summarized in the first part of the Majority Committee Report (through 4), and the above comments, it is my recommendation that the reference committee and House of Delegates oppose the further certification of physicians' assistants in Georgia and that those presently certified be left undisturbed.

In closing, I would respectfully request the reference committee and House of Delegates review the reports of last year in detail, as well as all those submitted this year, before reaching a conclusion of this important matter which so vitally affects the future of medical care in this country.

EXHIBIT 1: AN OPEN LETTER TO PRACTICING PHYSICIAN ASSISTANTS IN GEORGIA

Dear Colleague:

For approximately three years the Medical Association of Georgia has struggled with developing a position statement on the Physician Assistant. You may recall that one year ago the Ad Hoc Committee on Physician's Assistants reported to MAGs' House of Delegates a supportive and yet, broad Position Paper on PAs, which was reviewed by Dr. Milton I. Johnson of Macon, Georgia. His anti-PA position and review served to have another Ad Hoc Committee assembled to continue to develop a paper on PAs.

Over the past year supervising, supportive physicians of PAs, Program Directors, GAPA representatives, and skeptical Georgia physicians have struggled to address the concerns expressed by a handful of physicians in the State. In order to prevent a recurrence of a year ago, I am requesting that *you* and your supervising physician 1) contact the attached noted delegate(s) (and alternate) from your county, to apprise them of the long-overdue need for a supportive statement from MAG on PAs (exclusive of nurse practitioners), as these delegates will be called upon to vote on this matter at the House of Delegates Meeting in April.

Moreover, *if at all possible,* 2) you and your supervising physician should plan to attend the MAG House of Delegates 123rd Annual Session in Macon on Friday, April 22 at the Macon Hilton. The Reference Committee on PAs (open to all members of MAG) will discuss the report of this Ad Hoc Committee on PAs. *Individuals such as Dr. Johnson have sought to control these meetings in the past.* With the support of all physicians employing PAs, we believe we can place the PA in a more positive light and thus, continue developing better health care in the State.

We have done a great deal to date to speak in your behalf. It is now time for you to assure your future by doing these two *critical* matters NOW!! We would hate to fail because of the lack of support, by practicing physicians who have a vested interest in your future.

If you should have any questions or concerns regarding this request, please do not hesitate to contact me.

With my kindest regards.

Sincerely,
ROBERT H. CURRY, M.D.
Director
Physician Associate Program
Emory University School of Medicine

REFERENCE COMMITTEE B

EXHIBIT 2: EXPERIMENTAL REIMBURSEMENT FOR "PHYSICIAN EXTENDERS"

Under present law, the services of physician extenders (PE's) are not reimbursable under the medical insurance part of Medicare (Part B) unless they are "incident to" a physician's personal services; i.e., they are rendered under the direct personal supervision of a physician.

Under Section 222(b)(1)(G) of the 1972 Amendments to the Social Security Act (P.L. 92-603), the Social Security Administration has announced a two-year experimental program which, under the conditions and in the manner described below, will permit payment during this period to physician practices for the *independent* services of physicians' assistants, nurse practitioners, Medex and similar non-physician health care providers.

During this two-year experimental period, eligible primary care practices employing PE's will be reimbursed for the PE's services to Medicare beneficiaries where there is no direct physician involvement—i.e., the physician does not provide a service directly to the patient during the visit. In order for a practice to be eligible to participate in the experiment, a physician must accept full legal and ethical responsibility for the services delivered by the PE, and the PE's services must be legally authorized by the State or sub-State area in which the services are delivered. Experimental reimbursement for PE services will be made only to a PE employer; there will be no direct payments to PE's.

Eligible practices will be reimbursed at one of four rates for Medicare covered services deliv-

ered by PE's. Practices choosing to participate will be assigned (by SSA) to one of these rates: (1) 100 percent of the supervising physician's maximum allowable charge for the service rendered; (2) 80 percent of the supervising physician's maximum allowable charge; (3) 62 percent of the supervising physician's maximum allowable charge (or cost, whichever is greater); (4) a "lump-sum" cost-related rate.

In an initial survey conducted in 1975, *expressions of interest in this reimbursement experiment were sought from graduates of physician assistant, Medex* and *nurse practitioner programs across the country.* Recent evidence of increased interest among physician extender practices has prompted the Social Security Administration to establish new eligibility criteria and enrollment procedures. The new criteria permit the participation of eligible practices employing PE's who completed formal training by December 31, 1976. Upon determination of eligibility, participating practices will be required to complete a "baseline" survey. Upon successful completion of the "baseline" survey, practices will start to receive reimbursement at one of the four payment levels described above.

Practices that wish to be considered for enrollment in this two-year experiment, or wish to receive further information regarding the experiment, should call collect to the University of Southern California, Division of Research in Medical Education, (Social Security contractor) at (213) 221-2147 from 9:00 a.m. through 4:00 p.m., California time. All such queries must be made by May 1, 1977, since *no* new eligibility determination will be made after that date.

EXHIBIT 3: EXECUTIVE SUMMARY OF THE PHYSICIAN EXTENDER REIBURSEMENT STUDY

For the purposes of the Physician Extender Reimbursement Study, "physician extender" (PE) refers to three types of non-physician primary care health practitioners:

1. *Nurse practitioner* (NP)—Registered nurses who have received from *4 months to 3 years* of continuing education enabling them to expand their functions to include basic diagnostic and therapeutic services.

2. *Physician's assistant* (PA)—Individuals, often with some previous health experience, who have received *2 years* of special training in basic primary medical care.

3. *Medex*—Individuals with substantial previous health experience who receive *1 year* of additional special training in primary medical care enabling them to perform basic diagnostic and therapeutic services.

Background

The impetus for the Physician Extender Reimbursement Study is what some consider an apparent dichotomy in Department of Health, Education, and welfare policy with respect to PE's. On one hand, *DHEW along with other Federal agencies* (including the Department of Defense and Veterans Administration) *has for many years sponsored PE training programs.* The Department did so in order to encourage the development of a potentially valuable manpower resource which may offer a solution to the problems of insufficient and maldistributed primary medical care providers.

On the other hand, valid and reliable information confirming their efficacy, cost-effectiveness and quality is limited. The multiplicity of training programs, their differing lengths, curricula and prerequisites make it difficult to determine when a particular PE is adequately prepared to do what he or she is doing. *National certification standards and program accreditation criteria are being developed,* but no consensus yet exists as to their adequacy in setting standards of acceptability for PE's. Given these circumstances, the *Social Security Administration's Medicare reimbursement regulations only permit reimbursement for PE services which are "incident to" a physician's services,* and which are performed under the direct supervision of the physician. Medicare regulations do not allow reimbursement for PE services provided in place of the physician's service. These regulations reflect the requirements of Section 1861(r) and 1861(a)(2)(A) of the Social Security Act.

This prompted the inclusion of Section 222 (b)(1) subpart (G) in the Social Security Amendments of 1972. The goals for physician extender reimbursement research are to determine *under what circumstances* Medicare, Medicaid, and other Federal health insurance programs should reimburse employers for PE services and the most appropriate, equitable, and noninflationary methods and amounts of that reimbursement.

The importance of such research grows daily. In 1974, there were approximately 3,500 formally *trained PE's in the United States.* That number will, based on current PE program enrollments, double within the next year. *Whether this manpower resource continues to grow, or even continues to exist, depends in part upon Federal reimbursement policies. The effect of such policy can only be magnified by the introduction of national health insurance.*

The Physician Extender Reimbursement Study

In line with the Section 222 objectives, the Office of Research and Statistics of the Social Security Administration has designed a study intended to test the impact of PE utilization on the delivery of primary medical care and the effects of alternative methods and amounts of reimbursement for PE services upon practice productivity and the cost of care for Medicare Part B beneficiaries.

The Physician Extender Reimbursement Study will attempt to answer the following questions:

1. Does the value of services provided by a PE exceed the costs of his or her employment: In practice productivity higher in practices employing PE's than in other practices?

2. Do PE's make a greater contribution to practice productivity when working *independently*

of physicians or when working under the close supervision of physicians?

3. Do practices employing PE's deliver more services than other practices?

4. Is the *quality* of services delivered by a PE as good as that delivered by a physician?

5. Does utilization of PE's result in a shift in locations where services are delivered by the practice (e.g., more home visits)?

6. Does Medicare rimbursement for PE services result in a shift in PE utilization towards serving Medicare beneficiaries?

7. Do Medicare total program costs increase with reimbursement for PE services? If so, why?

8. *Does reimbursement for PE services at a rate less than that allowed for physician services nevertheless stimulate the utilization of PE's? If so, how?*

The study consists of two major phases, the baseline data collection activity and the reimbursement experiment. It is anticipated that about 800 practices which employ PE's will agree to participate in the baseline effort. These practices will be identified through a survey of PE graduates whose names and addresses were obtained from their training programs. Also included in the baseline activity will be a group of comparison practices which do not employ PE's, but which are matched on the basis of practice location, practice arrangement, specialty, and size of staff. The matching data and eligibility information will be collected through a brief questionnaire mailed to both PE and comparison practices.

The baseline activity will be conducted through the use of a log-diary and questionnaire to be completed by participating physicians and PE's. This information will be used to describe differences between PE and comparison practice organizations and productivity. Specific information which will be collected includes professional characteristics of physicians and PE's, types and volume of services delivered by them, charges for services and patient characteristics.

When practices complete the baseline activity, they will begin to receive Medicare reimbursement for PE services at the lower of the actual charge or a maximum reasonable charge (less deductible and coinsurance). The *maximum reasonable charge will be set at one of three rates:* 1) the same rate as the supervising physician's reasonable charge; 2) 80 percent of the physician's reasonable charge; and 3) an average cost-related rate. Each Part B Medicare service area will be randomly assigned to one of these maximum reasonable charge rates. All participating practices within a service area will be subject to that maximum reasonable charge.

Experimental reimbursement will continue for 2 years. At intervals throughout this period, data similar to those collected in the baseline activity will be collected in the participating PE practices. For a subsample of PE and comparison practices, more detailed studies of productivity, costs, and quality of care will be conducted. Also, summary information on Medicare claims for PE services will be used to measure the impact of experimental reimbursement on program costs and costs to beneficiaries.

Analysis of experimental data will focus on changes in organization and productivity of PE practices associated with the reimbursement modes as well as on the impact of reimbursement on program expenditures and unit costs. The analysis of differences in practice behavior at given points in time during the reimbursement period will permit an assessment of possible future changes which may grow out of a change in the present Medicare reimbursement law.

REFERENCE COMMITTEE B

COMMITTEE ON PHYSICIAN ASSISTANTS CHAIRMAN'S REPORT (C40c)

Jack F. Menendez, M.D.

At the Annual Session of the MAG House of Delegates in 1974 an Ad Hoc Committee on Physicians Assistants was formed. The charge of this committee was to investigate this new paramedical group. The committee's first report in 1976 was referred to Reference Committee D, along with a critique of the report.

The Reference Committee heard much testimony concerning problems with the PA concept. These concerns centered around three areas:

1. Abuse of PAs by physicians in private practice.
2. Governmental distortion of the PA concept so that PAs are used to render medical care *in lieu of* a physician, rather than under supervision of a physician.
3. Efforts by PAs to achieve autonomy via efforts in the area of independent licensure.

CHARGE OF THE COMMITTEE

With this testimony before the Reference Committee, the Reference Committee and the House of Delegates charged the PA Committee "that MAG look into both actual and potential problems which exist in the development of the PA profession."

BUSINESS SESSIONS

The Ad Hoc Committee has met three times this year, and in essence the evidence has confirmed that there are, indeed problems with the PA concept.

1. Concerning abuse of PAs in the private practice sector, most of the evidence is word-of-mouth and therefore unconfirmable. There is a considerable amount of this testimony however, regarding Satellite Clinics, unsupervised Emergency Room usage of PAs, etc.

2. In the area of PAs seeking independent licensure, this was confirmed by me in correspondence and telephone communication to the Medical Society of New Jersey. A bill, SB 1354, now in committee, would allow PAs to function without MD supervision. This bill is opposed by the Medical Society of New Jersey.

3. The area of governmental distortion of the PA concept is the most disturbing to me. The committee, by correspondence and follow-up telephone calls by me, established that PAs render independent primary care in military troop clinics without supervision by

MDs. The Armed Services apparently intend to continue this distortion by establishing their own PA schools. There is also evidence that in the non-military areas, physician extenders are to be used to render primary medical care, without supervision by physicians.

4. A corollary of interest is that yet another group of physicians extenders, notably Nurse Practitioners has, by the route of independent licensure, succeeded in escaping effective MD control. They have become in essence, independent paramedical practitioners.

An additional charge was given to the committee by MAG Council, to recommend a course of action for the House of Delegates to consider. However, the complexity of the situation makes an objective assessment difficult.

In a country where 70% of the people live in cities and where less than 2% live more than an hour's ride from medical facilities, do we need another paramedical group to serve this segment of the population? Will this be "cost effective"?

In an effort to increase the primary care physicians, family practice residencies are burgeoning. By the early 1980's, the U.S. will have 50% more MDs than at the end of World War II. Might this not bring about a confrontation between primary care MDs and PAs?

In summary, the original PA concept has been distorted, mandating further consideration by the MAG; proving once again a variant on the old adage which states "the road to good intentions is paved with Hell!"

RECOMMENDATIONS

1. PAs certified by the Composite Board of Medical Examiners be required to fulfill the Georgia Association of Physicians' Assistants requirements of continuing medical education (100 hours every two years).

2. That abuses of PAs by physicians in the private sector, e.g., satellite clinics, emergency room care, etc., be monitored by the State Licensing Board and sanctions placed against abuse of PAs.

3. That the Medical Association of Georgia House of Delegates go on record as opposing efforts of independent licensure by PAs in the State of Georgia.

4. In the area of governmental distortion of the PA concept, the following steps be taken:

A. Instruct our AMA Delegation to present evidence of governmental distortion of the PA concept at the next AMA National Meeting.

B. Provide our Congressional Delegation with the same information.

C. Alert our physician members who serve on governmental liaison committees such as HSA, DHR, etc., of the same problem.

REFERENCE COMMITTEE RECOMMENDATION—The reference committee considered these three reports together since they covered the same subject with differing views expressed by members of the same committee. These reports provide important information on potential advantages of adding a PA to a physician's practice as well as some of the alleged abuses that are occurring in private and government settings.

The committee was impressed by the sincerity of the physicians who spoke on both sides of this issue. Lengthy, well-reasoned, and informative testimony was presented to the committee. The members of the reference committee wish to express their concern that open discussion of this item may have been inhibited by the presence of non-MAG members. Many delegates expressed this concern to the committee. As a result, additional testimony was received in executive session because some individuals did not feel free to testify during the hearing.

In considering what action should be taken by MAG on Physician Assistants, the reference committee was particularly impressed by comments concerned with the potential for abuse of the PA by the physician, government's distortion—especially the military—of PA usage, the impact of the PA on the quality of medical care, and the interest of the PA in independent practice.

The committee could not concur with the recommendation that further certification of PA's be opposed. This would be unfair to the PA's and their employing physicians both present and future. Additionally, there was doubt that such an action could realistically have any effect on the production or employment of PA's. On the other hand, the committee does not believe that MAG should endorse or unreservedly support the PA concept. Too many questions have been raised, too many actual and potential abuses have been identified. Not the least of MAG's concern should be the production of physicians and the effect this will have not only on medical practice but also on the utility of the PA in an environment that is oversupplied with physicians.

In reflecting on all of the concerns, the reference committee concluded that none of the recommendations offered were completely acceptable. Therefore, the reference committee makes these recommendations:

1. All three reports and all recommendations of the Committee on Physician Assistants should be received for information.

2. The MAG affirms that it is the obligation and duty of the physician to report any misuse of physician assistants to the Composite Board of Medical Examiners or other proper authorities.

3. The MAG strongly opposes independent licensure for Physician Assistants.

4. Because of MAG's concern about the government's distortion of the Physician Assistant concept,

a. The MAG delegation to AMA is directed to submit a resolution based on the information and evidence contained in the Physician Assistant Committee Reports to the next meeting of the AMA House of Delegates.

b. The Georgia Congressional Delegation should be similarly advised.

c. The MAG should provide this information and evidence to physicians who serve on government committees such as Health Systems Agencies, the Department of Human Resources, and others.

5. The Committee on Physicians Assistants is directed to present in report to the April 1978 MAG House of Delegates information on the status of Physician Assistants in Georgia, including:

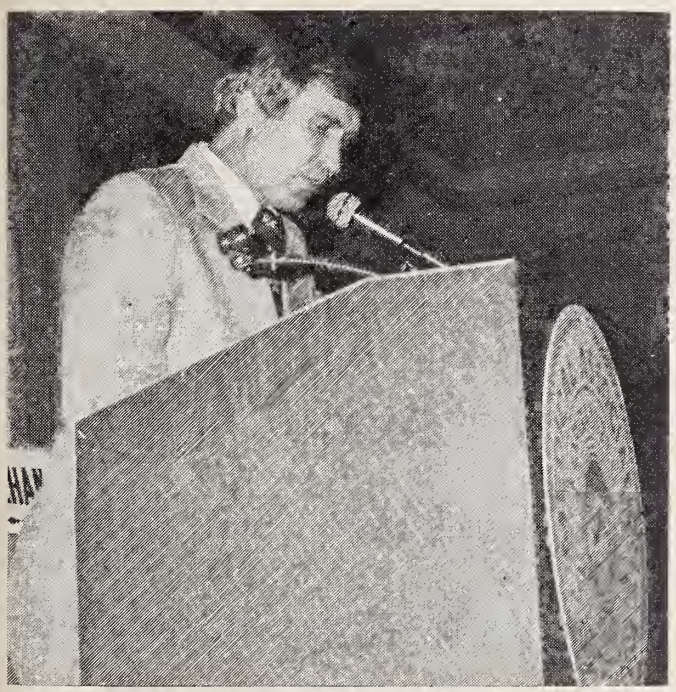
a. number of PA schools
b. number of PA students
c. number of PA's graduating
d. projected enrollment in PA schools
e. projected need for PA's
f. number of certified PA's.

Mr. Speaker, your reference committee recommends adoption of its recommendations.

HOUSE OF DELEGATES ACTION—Received the

three reports from the Committee on Physician Assistants (40a, 40b, and 40c) for information. The House then adopted the Recommendations on this subject as presented by the reference committee.

Chairman Galloway thanked the members of the reference committee and all those who appeared before the committee to express their views and expressed his appreciation to staff for their assistance in the preparation of this report.



Dr. Robert W. Oliver Jr.

REPORT OF REFERENCE COMMITTEE A

ROBERT W. OLIVER JR., M.D., Co-Chairman
LUTHER M. THOMAS JR., M.D., Co-Chairman

Chirman Oliver reported to the House of Delegates that reports and resolutions referred to Reference Committee A, which met on April 22 and 23, were carefully considered. The members of the reference committee present included: Robert W. Oliver Jr., M.D., Dulbin; Luther M. Thomas Jr., M.D., Augusta; William C. Waters III, M.D., Atlanta; Michel A. Glucksman, M.D., Brunswick; O. E. Ham, M.D., Savannah; Roy W. Vandiver, M.D., Decatur.

OFFICE OF THE FIRST VICE PRESIDENT (O/C4)

James H. Sullivan, M.D.

During the past year, as your First Vice President, I have attended all Council meetings and Executive Committee meetings. During the past two years, I have come to more completely appreciate the duties and responsibilities of being an officer of the Medical Association of Georgia and continue, with a great amount of humility, to face sometimes awesome problems which arise in the course of our deliberations.

REFERENCE COMMITTEE A

The many day-to-day housekeeping chores of the Medical Association of Georgia and the ramifications which come from malpractice, communication problems, health service areas, health maintenance organizations, and the acute and chronic problem of PSRO seems to fill more and more of our time. The Council of the House of Delegates has tried faithfully to carry out the wishes of the House of Delegates, and the Executive Committee has been much more responsive to the wishes of the Council and the House of Delegates in their decisions and deliberations.

At a meeting in early 1977 sponsored by one of our largest private insurance companies, it was pointed out that so called "experts," including college professors, insurance executives, federal bureaucrats, congressional budget advisors, stock brokers, bankers, economists, and actuaries, are the decision makers in our health care system today. They blame physicians exclusively for the problems that have arisen from increased medical costs to patients, hospitals, and medical care. They have actually charged physicians with joining in a conspiracy against third party payers to drive up medical and hospital bills. They accuse physicians of hospitalizing many patients rather than treating them in their own offices because it is easier, and physicians can earn more money per hour that way.

These so called experts, without any input from practicing physicians, blame us physicians for inflation in hospital cost because of the little things that are provided that make a hospital more convenient for doctors. They bring out the fact that 5 percent of the hospitals in the country have CT (scanners). They don't mention the fact that 95 percent of hospitals do not have CT scanners. They bring out the fact that 43 percent of our nation's 7000 hospitals have EEG facilities, while not mentioning that some 57 percent of the hospitals of this country do not have the technology to declare a patient legally dead without the aid of an EEG facility. These experts feel that each physician generates approximately $300,000 in health care costs per year, and they blame the physician for opening and closing the spigot for these costs. With the projection of 30 percent more physicians by 1985 predicted, they are concerned about the extra 35 billion dollars in total health cost which may be generated. In the preceding conference there were some 50 references to the cost effective mechanism but not a single reference to quality of care which the Medical Association of Georgia members are striving so much to bring to our patients.

We have a new President of the United States who has been a former Governor and friend of many Georgians in the past. We know for a fact that he has taken a stand against organized medicine and promises that we will have some form of national health insurance in the near future, depending on the financing available. Such a program could add another 100 billion dollars per year to our national budget. These facts do not make our future course in medicine any easier.

We must strive for professional accountability because, in spite of our best efforts, it is discouraging to see distorted or misinterpreted results in the media.

The cost of health care is a justifiable reason for public concern. Legislation proposing various approaches to national health insurance, the regulation of health manpower HSA's and, PSRO's are either under consideration or in various phases of implementation by federal mandate at the present time. It is extremely easy to explain the trend of our United States that seems to be transforming the health professions to the status of a public utility with consumer control rather than knowledgable physician, allied health professional input.

The Medical Association of Georgia and the medical profession in general has been taking its lumps and we have prided ourselves on the excellence of care we offer. We attempt to improve our standards and performance constantly and strive for quality of care, but cost accountability raises its ugly head in all the government programs considered, and we all know when government intervenes in any program, the cost of the program is increased tremendously over that controlled by private enterprise.

Another serious and deadly proposal on the horizon pertaining to licensure to practice medicine is being discussed in the back rooms of the halls of Congress. Licensure to practice medicine was originally established as a prerogative of all the individual states and has remained so to this present time. There is no federal agency at this time concerned with this or any other type of medical specialty credentials. Written into many of the considered plans for national health insurance is the problem of national licensure, which we must strive to defeat at all cost.

With so many problems in medicine it is a wonder that any of us wish to be involved in the alarming changes proposed to the practice of medicine with the many rules and regulations which are attempted to be cramed down our throats. With a greater percentage of the doctors of the State of Georgia belonging to the Medical Association of Georgia, the ranks of medicine in our state are being closed on a solid, fortified front. If we are to have any influence at the present time or in the future, we must stand together with the Medical Association of Georgia and an efficient American Medical Association.

It has been a privilege and an honor to serve the Medical Association of Georgia during the year 1976-77 as your First Vice President. Without the Staff of the MAG, it would be impossible for me or any Officer to function in our duties. It has been a privilege to serve with my fellow physicians in all meetings, to broaden my knowledge of the Medical Association of Georgia, and to help conduct the business of the Medical Association of Georgia. It has been an interesting phenomenon that more of our physicians have become involved in committee work requiring decisions which gain prominence every year. We have many crises and crises will persist potentially at any time during the future. With growing maturity, a stable outlook seems to prevail in the Medical Association of Georgia, providing solutions for the diverse problems we face on a day to day and year to year basis in such a large active association.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee read with interest the Annual Report of the First Vice President and appreciates his involvement and concern for Association affairs.

Mr. Speaker, your reference committee recommends this report be filed with commendation.

HOUSE OF DELEGATES ACTION—Report filed with commendation.

RESOLUTION 24
AFFILIATE MEMBERSHIP

DeKalb Medical Society

WHEREAS, Drs. S. Perry Brickman and W. Edwin Green are Oral Surgeons practicing in Decatur and hold affiliate membership in the DeKalb Medical Society, and

WHEREAS, Drs. Brickman and Green are members of the Georgia Dental Association and the Northern District Dental Society; therefore be it

RESOLVED, Drs. Brickman and Green be voted into affiliate membership in the Medical Association of Georgia.

COUNCIL
AFFILIATE MEMBERSHIP FOR MR. ARTHUR E. NOLAND (O/C6A)

Robert E. Perry Jr., M.D.

The Camden-Charlton County Medical Society petitioned Council for acceptance of Mr. Arthur E. Noland as an Affiliate Member of the Association.

Mr. Noland, a resident of St. Mary's, is a pharmacist who is a member of the Georgia Pharmaceutical Association. Mr. Noland has been an Affiliate Member of the County Medical Society for some time, but now by virtue of unified membership, must become an Affiliate Member of MAG.

Council has determined that Mr. Noland fulfills the requirements of the Bylaws (Chapter II, Section 5) and recommends that he be accepted as an Affiliate Member.

COUNCIL
AFFILIATE MEMBERSHIPS FOR DeKALB MEDICAL SOCIETY (O/C6H)

Robert E. Perry Jr., M.D.

The DeKalb Medical Society has requested affiliate membership in MAG for Perry S. Brickman, D.D.S., and W. Edwin Greene, D.D.S.

These two oral surgeons have been members of the DeKalb Medical Society for some time but now, by virtue of unified membership, must become Affiliate Members of MAG. They are members of the North Georgia Dental Society as well as the State Dental Association and applications for membership in MAG have been received as well as a letter request from the secretary of the DeKalb Medical Society.

Council has determined that Drs. Brickman and Greene fulfill the requirements of the Bylaws (Chapter II, Section 5) and recommends that they be accepted as Affiliate Members.

COUNCIL
AFFILIATE MEMBERSHIPS FOR CAMDEN-CHARLTON COUNTY MEDICAL SOCIETY (O/C6I)

Robert E. Perry Jr., M.D.

The Camden-Charlton County Medical Society peti-

tioned Council for acceptance of Messers. Marion J. Wainwright, Charles P. Stapleton, Meredith L. Hill Jr., and Henry A. Bennett for Affiliate Members of the Association.

All of the above are members of the Georgia Pharmaceutical Association, have been affiliate members of the County Medical Society for some time but now by virtue of unified membership, must become an Affiliate Member of MAG. Membership applications have been received by MAG from all of the above.

Council has determined that all of the above fulfill the requirements of the Bylaws (Chapter II, Section 5) and recommends that they be accepted as Affiliate Members.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee reviewed four separate items regarding affiliate memberships. These were considered by the reference committee at the same time.

Mr. Speaker, your reference committee recommends adoption of Resolution 24 and Council Reports 6A, 6H and 6I.

HOUSE OF DELEGATES ACTION—Adopted Resolution 24, Council Report 6A, 6H, and 6I.

OFFICE OF THE TREASURER (O/C8)

Carson B. Burgstiner, M.D.

The fiscal condition of the Medical Association of Georgia at the present time is very strong. This final annual report is a sad and sentimental one for me, since it represents my last such report as your Treasurer. I wish to express my gratitude to the membership for the privilege of having worked with so many dedicated and unselfish physicians, striving for a better medical association.

The 1976 House of Delegates faced one of the greatest challenges ever presented to that body. For the first time in Association history, MAG faced a potentially damaging deficit budgeting position. We could either stop providing services and lessen benefits to our members or ask for dues increase. The House, with an aggressive approach, increased the dues from $125.00 to $225.00 annually. The result has been very beneficial and has resulted in continuing growth of our association.

We have improved communications through the public media defending MAG policy and getting timely information sent to our membership in a monthly newsletter.

We have had outstanding socio-economic programs with help to members from a business standpoint. More continuing education programs have been developed for hospitals and specialty societies, therefore, benefitting our membership.

Our print shop, operating under the name of MAG Services, Inc., is a cost effective venture for MAG and another excellent member benefit.

The legislative posture of physicians in Georgia has improved through our additional monies and long and hard effort of our staff. Through Association efforts many pieces of legislation that would be detrimental to doctors have been checked. Progressive malpractice bills and changes in the State Medical Practice Act effectively prevented problems faced by medicine in Georgia.

REFERENCE COMMITTEE A

Another major expenditure was funding MAG's lawsuit against the State Medicaid Program, seeking relief from restrictive rules and regulations that impinge on independent judgment of the physician treating his patient.

A sliding dues schedule was established for relief of the financial burden on new physicians entering practice and older physicians nearing retirement.

The continuing and increasing demand made on our medical association will need to be met with more than money if we hope to gain any substantial degree of success. This means that we must attract every eligible physician into our membership and get them actively engaged in bettering our services to the membership and the public.

There are many privileges one may attain by membership in the federation of medicine. We accept them as part and parcel of our dues payment. There are also responsibilities that one must assume. One such responsibility is to be ever alert for ways to make our organization more effective. Perhaps the most disgruntled of our members are those who do not take an active role in shaping the organization.

I would like to thank the people most responsible for our financial success in these economically troubled times. Our director of finance, Mr. L. B. Storey Jr., is a devoted, loyal, conscientious and tireless worker. Dr. Tex Eldridge, our Chairman-emeritus of finance for many, many years, has given us wisdom that always brings us back to earth. Thanks to the Finance Committee and Reference Committee for their sincere efforts and genuine concern for the continued financial success of this organization. Kudos are never sufficient for the efforts of Jim Moffett and his staff. Many thanks for the extra hours and myriad administrative duties they perform.

What better time than 1977 to think of how a small number of like-minded persons, dedicated to a cause, can change virtually every course of events. We have the goal, preservation of the private practice of medicine and our profession, and we have an effective conduit through our medical organization. This can be an unbeatable combination if we want it to be. We, as individuals, will decide what course our profession will take. We, united as a group, can make that course a successful one.

Gentlemen, give us your time, talents and financial support, and with the help of God, the Medical Association of Georgia will rise to the top with the respect and confidence it so richly deserves.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee recommends that this report be filed with commendation.

HOUSE OF DELEGATES ACTION—Report filed with commendation.

AMA DELEGATION (O/C12)

Harrison L. Rogers Jr., M.D.

The Georgia Delegation to AMA has had an active

year. In June your Delegation attended the Annual Meeting in Dallas, followed in November by the Clinical Meeting in Philadelphia. Following the direction of MAG your Delegation presented seven resolutions to the Dallas meeting and one resolution to the Philadelphia meeting, as follows:

DALLAS

Resolution #16 (A-76) AMA Membership opinion polls on National Health Insurance

Resolution #15 (A-76) Resolution on Cocaine Supply

Resolution #13 (A-76) Resolution on Medical Ethics

Resolution #84 (A-76) PL 98-641 Health Planning and Resources and Development Act of 1974

Resolution #85 (A-76) Utilization Review Regulation

Resolution #17 (A-76) Fee Discrimination

Resolution #14 (A-76) Cost Accountability

PHILADELPHIA

Resolution #2 (C-76) Nationwide Peer Review

Each of these resolutions was vigorously supported by your Delegation in Reference Committee Hearings and on the Floor of the House of Delegates. In those instances where the resolutions were referred to the Board of Trustees or Council of the AMA for further consideration, the Delegation has provided additional information or background material. On occasion your Delegation has sent representatives to these meetings to personally present your views.

Starting with the Philadelphia meeting, the Delegation prepared a report for the MAG membership at the end of the session. Of the 160 separate matters of business before the House, summary reports of 30 were prepared and reported to the membership via the next issue of the "MAG Newsletter." It is anticipated the same process will be followed after each meeting of the AMA House of Delegates in order to improve members awareness of the AMA activities. Having already reported in detail to the membership, only selected items will be included in this report to the House.

AMA & JCAH

As is the case at each meeting of the AMA House of Delegates, many resolutions and reports deal with the relationship between the Joint Commission on Accreditation of Hospitals and the AMA. This was the case in 1976 at both the Dallas and Philadelphia meetings. In these meetings, the JCAH Executive Director John D. Porterfield, M.D., spent long hours with the reference committees explaining the operation of JCAH as well as its goals. The Delegates in general reacted favorably to his reports and overall left the meetings with a better understanding of the complexities of JCAH pronouncements. Importantly, support was given to the continuation of the voluntary accreditation process, rather than a federally directed one.

Such items as a more flexible delineation of medical staff privileges rather than the frequently required "laundry list" of rigid guidelines for various specialties was thoroughly discussed and action by JCAH directives promised. At both meetings the JCAH suggestions for Hospital Staff Bylaws revisions concerning "due process" for aggrieved physicians were discussed. The AMA House recommended that each state association take the responsibility for such review. In Georgia our Committee on Medical Practices has been charged with this responsibility.

The AMA Board of Trustees and the AMA Commissioners to the JCAH suggested that increasing participation of local physicians in JCAH accreditation activities would benefit the voluntary accreditation process and improve quality. The MAG Committee on Joint Hospital Surveys has addressed this issue and will present recommendations to the MAG House for its consideration.

NATIONAL HEALTH INSURANCE AND MEMBERSHIP POLLS

Multiple resolutions and reports dealing with NHI and the AMA sponsored version of this legislation were reviewed in depth. A MAG resolution suggested a poll of AMA members to ascertain the views of physicians across the country on this issue. Whereas past debate on this problem had been emotional and in at least one instance shortened by parliamentary maneuvers, at the Philadelphia meeting the debate was orderly, well prepared and complete. Lengthy presentations were received by the Reference Committee and subsequent debate on the floor of the House was thorough as well as thoughtful.

The ultimate action of the House, i.e., directing the reintroduction of AMA's bill on National Health Insurance was a decision made on the tactics of legislative maneuvering in the 95th Congress. Most of those Delegates supporting this position described their own opposition to a National Health Insurance Law, but felt the best tactical move was to have a bill before Congress which included the basic tenents of organized medicine as previously outlined by the House of Delegates. Subsequently the AMA bill has been introduced in both the House and Senate as HR 1818 and S 218.

RECOMMENDATIONS

That each County Medical Society and every delegate to the MAG House of Delegates resolve to reacquaint the MAG membership with the federation concept of the structure of "organized medicine." To support this resolve, your AMA Delegation will assure you cooperation in bringing your views to the AMA either by resolution or debate. As our membership feels adequately represented, the unity of purpose and goals so desperately needed in the next few years by our AMA officers facing critical issues in the practice of medicine will be attained.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your reference committee recommends adoption of the recommendations contained in this report.

HOUSE OF DELEGATES ACTION—Adopted the recommendations contained in the report of the AMA Delegation.

SPEAKER OF THE HOUSE OF DELEGATES (O/C9)

L. C. Buchanan, M.D.

At the conclusion of this third year term, the report of the Speaker of the House of Delegates is not ma-

terially different from that of the two immediately preceding years.

During the year now ending, your Speaker has faithfully attended all meetings of Council and meetings of the Executive Committee held within the State. In addition, many hours have been invested in other committee activities such as the Committee on Liability Insurance and Economics, the Committee on Health Care in the Jails, the Committee on Composite Board of Medical Examiners and the Committee on Annual Session.

In depth study has resulted in some changes in format for the current Annual Session in an attempt to expedite the proceedings and hopefully shorten the final Session of the House on Sunday which has been so lengthy on past occasions.

Throughout all these activities the Speaker has continued to uphold actions and directives of the House of Delegates and with some increasing frequency, has necessarily insisted that various activities of the Association be made consonant with such directives.

Active, enthusiastic involvement in Association affairs by a greater number of members statewide continues to be our greatest need. As stated by letter on January 28, 1977 to each Delegate and Alternate, I personally believe that primary attention to patient interests; a rededication by officers, membership and staff to absolute integrity in all affairs; some reorganization for increased efficiency; and a cessation of involvement with various socialistic programs funded by outside agencies need priority attention.

With humble appreciation I thank you for the opportunity to have served as Speaker.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your reference committee recommends that this report be filed with commendation.

HOUSE OF DELEGATES ACTION—Report filed with commendation.

AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA (D1)

Mrs. Milton F. Bryant Jr.

This year's Auxiliary activities began in April, 1976 during the year of our nation's Bicentennial, so it was thought fitting to have as a theme for the year, "Preserve the Heritage of American Medicine." At the Orientation meeting presented at the Annual Convention, it was suggested that ways in which this could be done might be through: 1. Community Service; 2. Health Education; 3. Legislative Awareness and Action; and 4. Informed Public Communication. Our county auxiliaries have been active in all of these areas and in many more as well.

June brought the Annual Convention of the Auxiliary to the AMA in Dallas, Texas. We were proud to have all of our delegates present.

The summer Executive Board meeting and educational seminars held in Atlanta in July provided further information and stimuli for county auxiliary programs and projects.

Augusta was the site of the winter Executive Board meeting in January of 1977, and provided a time for additional information as well as an idea exchange session between county presidents. We were happy to

REFERENCE COMMITTEE A

have as our guest the President of the Woman's Auxiliary to the Southern Medical Association, Mrs. Linus W. Hewit, who spoke to us on the projects of the Southern Auxiliary.

Our county auxiliaries have been active this year in such varied projects as the learning and teaching of cardiopulmonary resuscitation, swine flu immunization programs as well as making known the need for regular immunizations, screening programs for hypertension, diabetes, vision and hearing. There have been health education programs in safety and various aspects of leading a healthy lifestyle. One auxiliary has set up a "language bank" with 70 interpreters covering 20 languages to serve all hospitals, physicians and ambulance services in the county. In addition they have interpreters for the deaf to perform the same type of service in case of difficulty with communication. Three auxiliaries now have puppeteers performing an extremely professional and popular puppet show for elementary school children called "Drugs are a Drag." Each auxiliary has several teams and this show has been seen by thousands of Georgia school children. Requests for the show continue to flood in. One of these auxiliaries is laying the groundwork for a similar show to reach those students of the Junior High level. Assistance is given to hospitals, nursing homes, children's homes and schools for those with learning disabilities. Many scholarships in health related fields have been given over the state and our members have been highly successful in their fund raising projects to benefit their philanthropies. The activities mentioned only skim the surface of our auxiliary work this year. A full account of the work accomplished will appear in the Annual Report of the Auxiliary to MAG.

It will be of particular interest to the members of MAG to learn of the growth and popularity of the Allied Health Careers Clubs of Georgia. So far this year five clubs have been reactivated, two new clubs formed and two clubs are in the process of being formed. Membership has increased and the programs being offered to our young people have been of high caliber. A continued growth is predicted.

Of interest also is the continued restoration and improvement in the Crawford W. Long Museum in Jefferson, Georgia. An original oil portrait of Dr. Long on loan to the MAA Auxiliary now hangs in the museum where formerly was hung a reproduction of this same painting. In addition, the Atlanta Historical Society has expressed a deep interest in mounting an exhibit in late 1978 on the history of medicine in Georgia. If sufficient funds can be found and sufficient information gathered, this could be an excellent method of showing the progress and service of the profession of medicine in Georgia. Those of you who are interested in this project or who wish to assist, may get further information by contacting the undersigned. The catalog, itself, would be a valuable reference book for any library, public or private.

In visiting our county auxiliaries throughout the state, in attending meetings of the MAG Council, and in attending the meetings of other organizations which are health oriented, it has become increasingly obvious

to me what a great potential we have in working together toward improving the quality of life for our people.

We wish to thank you—the members of the Medical Association of Georgia—for your continued support, cooperation and encouragement. We wish to be of help to you. Please continue to call upon us.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your reference committee recommends that this report be filed with commendation.

HOUSE OF DELEGATES ACTION—Report filed with commendation.

GEORGIA MEDICAL CARE FOUNDATION (D2)

Earnest C. Atkins, M.D.

The past year has been one of considerable activity, expansion, and change for the Georgia Medical Care Foundation. I would like to take this opportunity to highlight for you some of the more important items of occurrence this past year.

MEDICAID

The three major areas of activity within the Medicaid Program for the Foundation are Hospital Review, Physician Review, and Nursing Home Review.

The Nursing Home Program continues to function extremely well and at a high level of activity. During the past year nearly 46,000 Medicaid patient visits were made by Foundation on-site teams composed of a nurse, a social worker, and a private practicing physician, to evaluate the quality of care received by these patients. The results of this high level of activity are beginning to become apparent. Since 1973, when the program was first implemented, there has been a significant shift in the distribution of nursing home beds throughout the State. In 1973 the distribution of beds was 80% Skilled and 20% Intermediate. By the end of 1976, the distribution had shifted to 42% Skilled and 58% Intermediate. Additionally, the Foundation has assumed the responsibility of performing all of the utilization review required of nursing homes under Federal and State regulations for a total of 351 facilities.

Activity in the Hospital and Physician Review Programs, however, has proceeded at a significantly reduced pace, due apparently to claims processing problems within the Georgia Medicaid Program. Dialogue has taken place concerning this sharp decrease in claims flow and, at the time of the writing of this report, it appears that steps are being taken within the Medicaid Program to correct the problem.

MOVE TO MAG

As directed by the Council of the Medical Association of Georgia last summer, the Foundation terminated its lease agreement with Selig Enterprises for its office at 1100 Spring Street and, effective January 1, 1977, occupied the space at 938 Peachtree Street, formerly occupied by the Georgia Regional Medical Program. The move went quite smoothly and the cooperation of the staff and officers of the Medical Association of Georgia is appreciated.

MEDICAL DIRECTOR AND NEW DIRECTORS

At its regular meeting in January, 1977, the administrative membership of the Council re-elected the Directors and Alternate Directors of the Third, Sixth, Ninth, and Tenth Districts for new three year terms. Additionally, in the Fall of 1976, Jack F. Menendez, M.D., assumed the newly created position of Medical Director of the Foundation.

NEW SPECIALTY PANELS

The past year has seen the establishment of two new specialty panels within the Foundation. The psychological Specialty Panel was formed with the concurrence of the Georgia Psychiatric Association. The second new specialty panel is in the Nursing Home Program and is concerned with Long Term Care. This panel will consider appeals of nursing home patient placements in Georgia and will bring such appeals under the auspices of the Foundation rather than the Medicaid Program.

SELF-EVALUATION

The institutional self-evaluation described to you in our last report to the House of Delegates has been completed, and copies of the entire evaluation have been distributed to all the members of Council. This evaluation has been, perhaps, one of the most significant undertakings of the Foundation to date and, again, all possible gratitude and recognition must be extended to John R. McCain, M.D., for undertaking and overseeing this extremely valuable project.

FOUNDATION INTERACTION WITH NON-MAG PHYSICIAN GROUPS

The past year saw the establishment of an open working relationship between the Foundation, the Medical Association of Georgia, the Metropolitan Atlanta Foundation for Medical Care, the Georgia State Medical Association, the Medical Association of Atlanta, and the Georgia Osteopathic Medical Association. One of the major accomplishments of this communication was the addition of representatives of the Georgia State Medical Association and the Georgia Osteopathic Medical Association to the specialty panels of the Foundation. I think that this represents a tremendous step forward in the conduct of peer review and the assurance of the Foundation's goal of excellence in medical care for the patients of Georgia.

ADMINISTRATIVE SUPPORT

To support the above described activities and to supplement future Foundation activities and programs, in January, 1977, the Board of Directors voted to proceed with the implementation of a microfilm storage system of Foundation documents which will be aided by a computerized indexing of these records. This combined system will make Foundation records available in a compact and readily accessible manner as well as enable the Foundation to provide specialized studies and information heretofore unavailable in the State of Georgia. The computer portion function of this program is being implemented on MAG's computers.

I also wish to commend the outstanding performance of the GMCF staff. They are: Mr. James Moffett, Executive Director; Mr. John Voigt, Executive Secretary; Mr. Bob DiProva, Associate Secretary; Mrs. Jean Buice, Director of Hospital and Physician Review; Mrs. Polly Stanley, Director of Nursing Home Review; and Mrs.

Joan Zoranski, Administrative Assistant to Mr. John Voigt, and all the other loyal and dedicated people. It has been a genuine pleasure to be associated with such an excellent staff.

This has been a brief review of the many areas of activity within the Foundation over the past year. I would be happy to answer any question that you might have concerning these items, or any others relating to the Foundation. The support of the Medical Association of Georgia for the functioning of the Georgia Medical Care Foundation is important, and I know that I speak for each member of the Foundation's Board of Directors when I tell you how much we appreciate it.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your reference committee recommends that this report be filed with commendation.

HOUSE OF DELEGATES ACTION—Report filed with commendation.

RESOLUTION 4
PRINTING AND STATIONERY SERVICES TO THE MEMBERSHIP, MEDICAL ASSOCIATON OF GEORGIA

Harvey M. Newman, M.D.
Hall County Medical Society

BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia direct the Association and its staff to withdraw from offering printing and stationery services to the membership at large.

REFERENCE COMMITTEE RECOMMENDATION —This resolution proposes that the Association withdraw printing services now offered to the membership. Mr. Speaker, your reference committee discussed at some length this resolution and arrived at the conclusion that the Print Shop had not been given sufficient time to prove its efficacy.

Therefore, your reference committee recommends that this resolution be not adopted.

Your reference committee further recommends that the House of Delegates call for a progress report on the printing services offered by MAG Services, to be presented to the House of Delegates at its 1979 Session, and that the MAG Council continue to monitor the progress and cost of the printing operations.

HOUSE OF DELEGATES ACTION—Voted that Resolution 4 be Not Adopted and concurred in an additional recommendation made by the reference committee: to wit, that the Progress Report on MAG services be presented to the House of Delegates at its 1979 Session and that the MAG Council continue to monitor the progress and cost of the printing operation.

OFFICE OF THE PRESIDENT (O/C1)

Fleming L. Jolley, M.D.

The strength and weakness of this federation of medical societies called the Medical Association of Georgia has been in the free service rendered by practicing physicians. The tasks rendered in the weekend meetings of those willing to give up additional time away from their families can never be underestimated —ask their wives. Their admixture of philosophies ac-

REFERENCE COMMITTEE A

counts for many hours in approaching any course of action upon issues that this federation encounters.

The admirable staff that is in the MAG office is doing a better job than most of us deserve. Decision-making is not something that can be easily relegated to monthly executive meetings, quarterly Council meetings, or annual or quarterly committee meetings.

I'm proud of the men with whom I have had the pleasure of serving on Council and as your officers, they have done you an excellent job.

The AMA delegates and alternate delegates have served you well. The two medical students attending the December Philadelphia AMA meeting were worth every cent of their fare. The good word will get to the medical schools as a result of this endorsement by MAG.

With the specialty societies, MAG has established closer ties. Through the scientific sessions, staff assignment to each society, and unifying in legislative activities, this has been accomplished.

Sure, not everyone is happy in this federation, but I personally believe the routes of communication have opened more and despite those differences of opinion, this unified MAG is more visible as a working cohesive organization.

Unfortunately, not every practicing physician in Georgia is a Medical Association of Georgia member. So, when MAG speaks, it does so for approximately 4,400 of the 5,300 serving the people.

How does one measure quality of care? And what is MAG's role in behalf of quality care? Much has been said of this by us, third party payers and patients or their representatives.

Can quality of care be measured by the number of grievance suits instigated against physicians? Certainly, quality of care cannot be measured by cost of care nor delivery of treatment cost. Yet, the use of cost containment and delivery of quality care seem almost interchangeable terms in our society today.

Neither recertification nor relicensure can guarantee maintained excellence of quality in delivery of physicians' services, nor in services rendered by non-physician personnel. Yet, these second and third level subspecialized services are recognized as care-oriented in the physician's role of responsibility. Are not we talking about substitution rather than an extension of the physician's arm?

The Georgia Medical Care Foundation has expanded its role in these two areas of quality care and fiscal responsibility through an encompassing involvement of more physician groups.

Improved knowledge of the physician is gained through many sources. In consort with the medical schools, hospitals, specialty societies, county and district medical societies, the educational arm of MAG has extended its involvement. Gaining a certain number of attendance points to CME courses for MAG membership is not likely to alter quality care.

The relationship of MAG to the State Board of Medical Examiners has increased significantly. In this manner, there seems to be a more valid approach to the protection of the physician and the patient. If the

phrase "physicians policing their own" has meaning, it remains the Board's responsibility to so judge. Herein, the MAG should have input as consultants not only in the areas of provisional and institutional licensure, but also paramedical activities. In addition, the surveillance of rehabilitated and disabled physicians for whatever cause as well as those acts of questionable medical practice can be best supervised. MAG does have constitutional responsibility in recommending who serves on that Board as of 1976.

The recent studies on maldistribution of physicians in part concludes that 117 counties of the 159 in Georgia are under-served. However, it seems questionable that treating the sick can be delineated by arbitrary demographic lines of government. Transportation is frequently heard as a complaint in obtaining the physician's service. How valid is the complaint that "emergency treatment" is not available in rural areas? One physician's wife writes: "Where are the young doctors?"

What part does MAG have in containment of cost? Every third party looks upon the physician as the entry point for an individual into the health care system, business, or whatever term one wishes to use. This was pointed out very clearly by the HEW abuse and fraud examining team for Medicaid in Georgia. It will be some months before a final review is available from this investigative team, but the word left upon their return to Washington was one of an encouraging nature for our membership. This did not surprise us.

As much continues to be written and spoken about cost of health, we may become confused by the million and billion dollar signs. I think, however, as one puts the percentage of the total national health product, it becomes more realistic. Compare 8.5% for health to 3% for alcohol and tobacco.

Good health contains cost. That, of course, is not an original statement anymore than most of these thoughts are, and yet it again directs attention to preventive medicine. How can, and where does, MAG make its input? Certainly, early school education should be one site, if not the most important site. Has not the role of the young teenager become more prominent in the trauma of crime, pregnancy, self-pollution with drugs, tobacco, etc.?

Preventive education, early detection, restoration of good health, and palliative comfort is what it's all about for us.

Even though we are already the most regulated profession, we should be able to cope, maintaining our individual or private identity as a group.

The Medical Association of Georgia must continue its self-assessment in both long range and short range goals. The basic framework of its organization has evolved to blend new ideas with the stability of maturity.

Let us not default in anger, disgust, nor absence.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee recommends that this report be filed with commendation.

HOUSE OF DELEGATES ACTION—Report filed with commendation.

OFFICE OF THE PRESIDENT EXPANDED REPRESENTATION TO THE HOUSE OF DELEGATES (O/C1A)

Fleming L. Jolley, M.D.

Over several years, MAG at the Executive Committee, Council and House of Delegates levels has considered extending the representation in the House to physician groups beyond county medical societies. Usually, this has been in terms of specialty societies or house staff. Past efforts to add representatives of these groups have not been successful. I believe that MAG should enlarge the circle of contributors to the policy-making process of the Association. All physician groups which have a particular interest to be represented should have a direct voice in the affairs of the Association. We should give all of them a hearing and a vote. If we do not allow the physician members of these groups the right and opportunity to participate, then we may very well lose their allegiance as well as leave them little choice other than to promote their interest through a separate organization.

RECOMMENDATION

In order to accomplish this objective of bringing these physician groups into the MAG House of Delegates, the House of Delegates should establish specialty society sections and representation for house staff, medical students, medical school faculty, public health physicians, military physicians, nursing home medical directors, directors of medical education and other groups as an interest is expressed by them. Each of these groups should be granted one delegate and one alternate delegate who must be MAG members. These delegates would be selected by their respective organizations. They would have all the rights accorded to a regularly elected county medical society delegate.

REFERENCE COMMITTEE RECOMMENDATION —Mr. Speaker, your reference committee has taken note of the fact that the House of Delegates has addressed this and similar issues in the recent past and has chosen to disapprove them. One of the primary reasons for the disapproval in the past has been the potential increase in the size of the House of Delegates. It is also the opinion of your reference committee that adoption of this recommendation would result in disproportionate representation in the House as well as create the possibility of having delegates elected by physicians who may not be members of MAG.

Mr. Speaker, your reference committee recommends that this report be not adopted.

The reference committee further recommends component medical societies having significant medical student and house staff populations in their area should encourage their active participation in all Association affairs.

HOUSE OF DELEGATES ACTION—Report of the President 1A not adopted. The House concurred in a further recommendation of the reference committee that those component medical societies having significant medical student and house staff population should encourage their active participation in all Association affairs.

COUNCIL RESOLUTION FROM GEORGIA SOCIETY OF ANESTHESIOLOGISTS (O/C6D)

Robert E. Perry Jr., M.D.

The resolution that appears below was presented to Council in January 1977 with a request that it be endorsed by Council and referred to the House of Delegates for approval. The resolution originated with the Georgia Society of Anesthesiology.

The Georgia Thoracic Society took a contrary view from that expressed by the resolution, and, as a consequence, the Council voted to refer the matter to the House of Delegates without recommendation. The resolution is as follows:

WHEREAS, activity in respiratory therapy has historically had a strong identification with the specialty of Anesthesiology, both nationally and in the state of Georgia, and

WHEREAS, a survey conducted in 1974 by the Georgia Lung Association listed 24 physicians in the state practicing Anesthesiology who were Medical Directors of hospital Respiratory Therapy Departments, and

WHEREAS, the two training programs of Anesthesiology in Georgia (Emory and the Medical College of Georgia) provide training in respiratory care which involves management of respiratory problems in the peri-anesthetic period, and

WHEREAS, there is presently only limited provision for further training within Anesthesiology training programs for intensive respiratory therapy, particularly in the post-surgical patient, therefore be it

RESOLVED, that the Georgia Society of Anesthesiologists affirm that intensive participation by the anesthesiologists in the pre- and post-anesthetic respiratory care of surgical patients can be a logical extension of their intraoperative anesthetic care of surgical patients, and be it further

RESOLVED, that Directors of training programs in Georgia be encouraged to develop increased training in intensive respiratory care within their programs, and that the Georgia Society of Anesthesiologists actively seek support for fellowships in respiratory care for residents, utilizing any financial resources which are appropriate to such activity.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee has an appreciation for the principals as set down in the resolution. We recognize that these programs would provide a vitally needed service. However, it was the feeling of your reference committee that this report was an inappropriate matter for the House to consider. It was the consensus of your reference committee that further work should be encouraged by institutions and specialty societies that are directly involved.

Your reference committee recommends that this report be filed.

HOUSE OF DELEGATES ACTION—Report filed.

OFFICE OF THE SECRETARY (O/C7)

Earnest C. Atkins, M.D.

As my fifth year as Secretary nears an end, it continues to be apparent that the activities of the Medical Association of Georgia, both in number and complexity, are rapidly accelerating. The leadership ability of the members, Council, Executive Committee, Committee Chairmen, Headquarters Office Staff, CHAMPUS Staff, MAG Services, Inc. Staff and the Staff of the Medical Care Foundation continues to be more and more evident. It is a genuine pleasure to serve with such dedicated and effective people.

CHART I

The membership of the Medical Association of Georgia continued its upward climb during the year 1976. The rate of growth increased by 50% over the previous year. In 1976 we increased our membership: active 86 and total membership 86. In 1976 we increased our active membership to 3,827 and our total membership to 4,348. Our AMA membership is at an all time high, 3,347 in 1976 as compared to 3,259 in 1975, a net gain of 88. Estimated number of licensed physicians residing in Georgia as of the end of 1976 was 6,200.

Although we had a good membership year both at the MAG and AMA, the big concern to me is the 1,800 of Georgia's physicians who are not members. We should continue to serve our present membership even better and employ the advantages of organized medicine so that all physicians in Georgia will rally to swell our ranks. At the end of this report, I will make recommendations to increase our membership.

GEORGIA REGIONAL MEDICAL PROGRAM

This program has been phased out and has also moved out of the MAG Headquarters office building.

Very few know and appreciate the hard work and dedication to MAG that its director, J. Gordon Barrow, M.D., exhibited over many years.

I also appreciate and recognize the fine job done by our two coordinators, Charles Adair, M.D., and Luther Vinton, M.D.

Membership Report

	1976	*1975*	*1974*	*1973*	*1972*
Active	3827	3741	3738	3456	3418
Active I & R	47	40	24		
DE-1	61	65	59	63	62
DE-2	15	15	19	21	31
DE-3	32	32			
DE-4	11	12	11	10	15
Life	191	191	167	179	184
Associate	93	99	133	111	106
Service	66	62	55	65	60
Honorary	1	1	1	1	1
Affiliate	2	2	1	1	1
Student	2	2	2	1	3
TOTALS	4348	4262	4210	3908	3881
AMA Membership	3347	3259	3264	3190	3117

CHAMPUS PROGRAM

In June of 1976, we changed the computer portion of our contract from a service bureau to in-house with subcontract with Emory University. This has worked

REFERENCE COMMITTEE A

beautifully. We retained the service bureau for data entry on a temporary basis. We are now in the throes of converting to in-house entry which will give us complete control of our system. We will most likely have to add one or two people for entry, but we are using people already employed as much as possible. As of January 1976, we had 41 people on our payroll. We now have 38.

During 1976, we had the lowest percentage increase ever—1% average. We had a 9.6% reduction in in-patient claims, probably related to requirement for non-emergency hospital care to be provided in a military facility if the patient lives within 40 miles of the base and the care is available there. Out-patient claims, which require more work to pay, increased 4.2% and prescription drugs by 16.6%.

The amount of money expended per claim for physician care continues to decrease. Prescription drug costs have remained fairly stable at $30-$35 per claim (about 10 Rx average) since 1970. Regular claims, which reflect physician charges, have decreased from $102 in 1970 and $104 in 1971 to $91 for 1976.

Also, note that we processed (this includes claims returned, rejected and paid) $125,000 claims per year or 500 claims per day, expending $7,589,174.13 for health care in Georgia during 1976.

President's *Reception*







6:00



Dr. Fleming Jolley hosted the President's Reception Saturday evening. Shown in the receiving line: Dr. Milton F. Bryant Jr. and Mrs. Atchie Bryant, 1976-77 President of the Auxiliary; Mrs. Betty Andrews, 1977-78 President of the Auxiliary; Mrs. Anne Jolley and Dr. Fleming Jolley, 1976-77 President of MAG; Mrs. Frances Astin and Dr. Russell E. Andrews Jr.

CHAMPUS—GEORGIA 1975-76 STATISTICAL REPORT

Claim Flow	*Annual*		*Average Per Month*		*Average Per Day*		*Percent of Total*		*Percent of Annual Change*	
I Number claims received	*1975	1976	1975	1976	1975	1976	1975	1976	1974-75	1975-76
1) Inpatient	40,210	36,364	3,350.8	3,030.3	160.8	145.5	33.7	30.0	22.1	(9.6)
2) Outpatient	64,244	66,928	5,353.7	5,577.3	251.0	267.7	53.9	56.0	30.0	4.2
3) Drugs (vendor or reimb.)	14,471	16,874	1,205.9	1,406.2	57.9	67.5	12.2	14.0	20.7	16.6
4) Handicap	210	145	17.5	12.1	.8	.6	.2	0	66.3	(31.0)
Total	119,135	120,311**	9,927.9	1,025.9	476.5	481.3	100.0	100.0	26.6	1.0
II Claims Processed										
1) Returned	15,398	18,096	1,283.2	1,508	61.6	72.4	12.9	14.5	39.7	17.5
2) Rejected	19,414	15,230	1,617.8	1,269.2	77.7	60.9	16.3	12.2	70.3	(121.6)
3) Review commitee	149	181	12.4	15.1	.6	—	.001	—	148.3	—
4) Paid										
Applied toward ded.		967								
(a) Inpt.-outpt.	72,007	76,299	6,000.6	6,358.3	288.0	305.2	60.4	61.0	40.9	5.9
(b) Drugs	12,011	V 2,159 R 11,950	1,000.9	1,175.8	48.1	56.4	10.1	11.3	50.6	17.5
(c) Handicap	218	150	18.2	12.5	.8	.6	.2	—	(67.6)	—
Subtotal paid claims	84,236	91,525	7,019.7	7,627	366.9	366.1	70.7	73.2	44.9	8.6
Total claims processed	119,197	125,032**	9,933.1	10,419.3	476.8	500.2	100.0	99.9	18.3	4.8
III Difference I-II	62	4,721	5.2	—	.25	—	—	—	—	—
IV Funds disbursed										
1) Reg. (inpt./outpt.)	6,860,044.51	6,960,943.86	571,670.38	580,078.66	27,440.18	27.843.77	93.0	—	33.5	1.5
2) Drugs R-reimbursement	424,223.99	R 532,790.21	35,352.00	R 44,399.18	1,696.90	R 2,131.16	5.7	—	54.8	27.8
V-vendor		V 9,533.26		V 794.44		V 34.13				
3) Handicap	96,359.98	85,906.80	8,030.00	7,158.90	385.44	343.63	1.3	—	(61.37)	(10.8)
Totals	7,380,628.48	7,589,174.13	615,052.37	632,431.18	29,522.52	30,356.69	100.0	—	30.4	2.8

V Average Disbursements Per Claims			
1) Regular (Inpt./Outpt.)	95.27	91.23	
2) Drugs—Vendor	35.32 Avg.	4.42	38.44 Avg.
Reimb.		44.58	
3) Handicap	442.02	572.71	
Overall average	61.92	60.70	

* 1975 Drugs included both Vendor and Reimbursement.
** It is possible to process more claims than received because of re-processing returns and separation of claims into two different claims for processing.
( ) Credit Items.

MAG FOUNDATION

The MAG Foundation (Benevolent) grows continually. The bank balance as of December 31, 1975, was $13,150.93 and as of December 31, 1976, decreased to $11,422.93 due to donation to the Crawford W. Long Museum.

There is included in MAG's annual budget $1.00 per paying member to be allocated to the Foundation in order that a fund may be established to assist indigent physicians and physicians' widows.

The MAG Foundation also administers donations and loans to physicians for the Disabled Doctors Program.

Again, the Foundation expresses its gratitude to the various County Society Women's Auxiliary for their numerous contributions to the Scholarship Fund.

We also paid $1,728.00 for a new roof for the Crawford W. Long Museum at Jefferson, Georgia. We are proud of MAG's involvement in this historical landmark and cordially invite each of you to visit it this year.

The activities of the Foundation are governed by a six-man board, and the expiration date of their terms follows:

Charles R. Andrews, M.D., President	1977
J. Rhodes Haverty, M.D., V-President	1978
Carson B. Burgstiner, M.D., Sec.-Treas.	1979
Earnest C. Atkins, M.D.	1980
James M. Moffett	1982

Statement of funds in the care of the Benevolent Foundation follows:

	1975	*1976*
Cash—Student Loan Fund	$ 3,684.01	$ 2,476.46
Notes Receivable—Student Loans	51,908.65	54,819.20
Total—Student Loans	$55,592.66	$57,295.66
Funds for Indigent Physicians		13,150.93
Less—Roof for Crawford W. Long Museum		1,728.00
Total Indigent Funds		$11,422.93

On July 16, 1976 a MAG physician donated $500.00 which has been credited to the Disabled Doctors Program.

WATS LINE (1-800-282-0224)

This toll-free telephone service now speaks for itself, and expanding our communications is the word of the day.

GEORGIA MEDICAL CARE FOUNDATION

Again, a separate report is given, but the fine spirit of cooperation between the Executive Secretary, Mr. John Voigt, and his staff, with MAG deserves attention and commendation.

HEADQUARTERS OFFICE

The Headquarters Building continues to serve as a focal point for the operations of the Association. With every segment of operation growing, expansion is the word of the day.

The Georgia Medical Care Foundation relocated to our building on January 1, 1977. In addition to the rental income, a close adhesiveness of these two organizations now exists.

Our Headquarters Office Staff is continually growing in response to an enlarged membership and a vast number of projects and activities. The total personnel at MAG in the various related activities that are sponsored by MAG is 110. A breakdown of personnel by department is as follows:

CHART 3

	1975	*1976*
GRMP	28	0
MAG Auxiliary	0	1
MAG (including Secretary, Treasurer and JMAG Editor)	19	17
CHAMPUS	42	37
Research and Development	14	11
GMCF	47	42
MAG Services, Inc.	1	2
	151	110

MAG SERVICES, INC.

We are now contracting with the State of Georgia to operate the Cancer Registry.

The print shop is in full operation. Its quality of work is superb and is now nearly supporting itself. We expect to have our debts to MAG (including interest) liquidated within three years.

We solicit your orders for stationery, prescription pads, etc. We offer fine quality work on short notice at a considerable saving.

RECOMMENDATIONS

Expanding membership is a vital concern of MAG as well as to our component Medical Societies. Accordingly, I would like all road blocks removed to assure increased membership.

1. MAG's future lies in its younger members: physicians entering practice, interns, residents and medical students. I challenge each of you to interest a young non-member in joining MAG this year.

2. Direct the membership committee to institute and oversee a project to procure and involve tomorrow's medical leaders.

LET'S DO IT!!

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee read with interest this report and appreciates the efforts of the Secretary. We would call the House's special attention to the section of the report dealing with MAG Services. In the second paragraph of that section, the report states that the print shop is "now nearly supporting itself." Your reference committee wishes to point out that this statement is not borne out by financial statements of MAG Services. We call the attention of the House to the previous resolution dealing with the print shop (R-4).

Your reference committee recommends adoption of Recommendation 2 and further recommends that the balance of the report be filed.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 2 and agreed that the balance of the report be filed.

JOINT GEORGIA HOSPITAL SURVEY PROJECT (C19)

Harrison L. Rogers Jr., M.D.

The Joint Hospital Survey Project Committee was charged with and evaluated the possibility of eliminating one or more hospital surveys and found that, for Georgia, such a plan is impossible at this time. This

subsequent proposal is felt by the Committee to be a worthwhile endeavor for physicians in Georgia. The report describes the Joint Georgia Hospital Survey Proposal which may be jointly sponsored by the Medical Association of Georgia (MAG), the Joint Commission on Accreditation of Hospitals (JCAH), and the Georgia Hospital Association (GHA).

PROPOSAL

It is proposed that MAG investigate the possibility of including a Georgia physician on the JCAH survey teams within the State. Such a physician would serve as a liaison between the hospital medical staff and visiting JCAH surveyors. In this capacity, the Georgia physician would be actively involved in evaluating the patient care evaluation and continuing medical education activities regularly carried out within the institution, as well as the organization, delivery, and documentation of medical care. Benefits derived from this would include improving the overall quality of the JCAH survey, strengthening wherever possible the institution's audit and education programs, establishing more effective channels of communication between the medical and hospital communities, and enabling MAG to take an active role in identifying and appropriately coping with patient care issues on a statewide basis.

It is anticipated that the Joint Hospital Survey will be a permanent activity in Georgia, with a major long-term role in the evaluation of quality care and continuing medical education activities according to JCAH standards. The ultimate goal will be for the MAG physician to replace the JCAH physician as a member of the survey team in Georgia hospitals. Preliminary communication with JCAH representatives indicate their willingness to consider such a proposal.

IMPLEMENTATION SCHEDULE

Phase I

1. Investigate the existing situation with regard to JCAH surveys in Georgia, as well as a similar, but not identical, consolidated hospital survey in California.
2. Plan an experimental program to be initiated as soon as possible.
3. Travel to California by members of Joint Hospital Survey Committee and staff to attend one of the training workshops for survey physicians organized by the California Medical Association, followed by a visit to one or more institutions with survey teams to see how the program actually operates in California.
4. Travel to Chicago by committee members and staff to attend JCAH surveyor training sessions and complete arrangements for a cooperative effort in Georgia with the appropriate JCAH officials.
5. Poll MAG membership to identify individuals who would be interested in participating in such a program. Twenty-five to 50 physicians interested in obtaining the necessary background and willing to take part in one to four surveys a year will be needed to make this plan operational.
6. Arrange for physician volunteers identified in poll to accompany various JCAH survey teams during their Georgia visits in order to have a better idea of what to expect when they begin taking an active role in such surveys.

Phase II

1. Implement the experimental program as designed.
2. Organize and conduct training sessions for Georgia physician surveyors, with emphasis on:
   (a) medical audit
   (b) continuing medical education issues
   (c) establishment of formal arrangements for joint surveys by participating organizations
   (d) assumption of independent responsibility for the medical staff
   (e) evaluation of the program's overall impact on both the hospitals and the physicians involved.
3. Evaluate initial program and make recommendations for future activities in this area.

RECOMMENDATIONS

1. That this House of Delegates favorably consider this proposal, urge support for it, and direct its implementation.
2. *With favorable consideration by the House, the Georgia Hospital Association be requested to favorably consider this project, acknowledging the anticipated additional costs for the individual hospitals surveyed.*

REFERENCE COMMITTEE RECOMMENDATION—Your reference committee endorses the concept proposed in the report and feels that organized medicine should support JCAH. Your reference committee further endorses the concept of having Georgia physicians involved in surveys in our State.

However, your reference committee feels that such an expenditure as is called for in this report is premature.

Your reference committee recommends adoption of Recommendation 1 with the following amendment:

It is recommended that all words beginning with the word "it" in Recommendation 1 and continuing through to the end of the sentence be stricken. It is further recommended that the word "and" be inserted between the words "proposal" and "urge" and that the words "the concept." be added to the end of the sentence. Therefore, the amended recommendation would read: "That this House of Delegates favorably consider this proposal and urge support for the concept."

Your reference committee further recommends that Recommendation 2 not be adopted.

HOUSE OF DELEGATES ACTION—Adopted Recommendation 1 in the report, as amended by the reference committee. Voted that Recommendation 2 be not adopted.

REFERENCE COMMITTEE A

COMMITTEE ON MEMBERSHIP INSURANCE (C34)

W. Perrin Nicolson, M.D.

This committee, at the direction of the 1976 House of Delegates, reviewed the Southern Medical Association and American Medical Association insurance packages. In general, the SMA seems to offer a better value for comparable coverage. This varies slightly depending on the type of policy and the age of purchaser. SMA is especially attractive in cost when multiple coverage plans are purchased. The AMA policies do offer higher

levels of coverage. The Committee recommended and Council approved MAG continued endorsement of SMA's insurance coverage.

Another matter brought to the attention of the Committee is self-insurance. The Committee recommended to Council that MAG establish a self-insurance plan for the membership and their employees. The Council at its January meeting referred this question to the House of Delegates by strongly recommending that the House consider the matter of instituting a multiple benefit insurance trust. This concept is explained below.

MAG is investigating the possibility of utilizing a Self-Funded Health Trust as a service to its membership. The purpose would be to save money for the membership and employees, primarily in hospital and medical insurance on a more equitable basis. Savings from 15% to 35% may be obtained in hospital and medical insurance, depending on the program.

WHAT IS SELF-FUNDING?

Self-funding is not a new concept, but is receiving increasing attention as a mechanism for health care benefit programs. Should an employer say to his employees "Bring me your medical bills and I will pay them," this would be pure self-funding. The employer would then establish a fund that would be actuarially sound (see SPREADING THE RISK). The employer would then pay the medical bills from this fund and replenish the fund as necessary. Employers may accomplish this in many ways. Most often, he will opt to accept part of the risk and buy insurance for the rest. Should he desire, he may insure a part of his risk with excess loss insurance.

This can best be illustrated by a hypothetical example. Suppose a program was set up to have $100.00 deductible, 80% co-insurance up to $2,000.00, and pay all costs over $2,000.00 to a maximum of $250,000.00 per life time. Also, assume that the employee contributes $10.00 a month to this program. Should an eligible individual have claims of $5,000.00, the responsibility would be divided as follows:

$100.00—deductible	employee's responsibility
$380.00—20% of $1,900.00	employee's responsibility
$120.00—Monthly contribution	employee's responsibility (one year at $10.00 per month)
$600.00—Total of employee's responsibility	
$1,400.00—(see SPREADING THE RISK	employee's responsibility
$3,000.00—Major Medical	Insurance company's responsibility
$5,000.00—total expenses	

SPREADING THE RISK

Assume that an employer has 100 employees or that the Trust has 100 members. Now assume that during any one covered period, 20% of the members could be expected to have claims of $5000.00. The Trust/Employer responsibility would be 20 times $1400.00 or $28,000.00. This would result in a premium cost of $23.33 per month. This situation has never occurred, but should all 100 members have costs of $5000.00, the Employee/Trust cost would then be $1400.00 times 100 or $140,000.00. The premium cost would then be $116.60 per month instead of $23.33 as could be expected under normal circumstances. This illustrates the savings that usually result when using a relatively large number of individuals to spread the risk. It must be emphasized that these figures are for illustration only and are not actuarially sound. Neither do they represent total cost. There would still remain the additional cost of administration. This additional cost would be approximately 20% of premium divided as follows: 10% for administration, 2% to 4% for excess loss insurance, and 5% for acquisition costs.

EXCESS LOSS INSURANCE

Excess loss insurance is that type of insurance pay all losses above an agreed upon amount. Now by quickly reviewing the example given above, an Employer/Trust of one hundred people would expect to pay $28,000.00, but might very remotely be liable for $140,000.00. Should the Employer/Trust be unwilling to accept this total risk, he may purchase excess loss insurance beginning at some point above premium, $28,000.00. This pick up point for stop loss insurance may vary from 105% to 200% of total paid premium.

TRUST

The formation of a Trust is best if an employer accepts employee contributions to avoid the inference of functioning as an insurance company. In the case of multiple employers, as in an association, A TRUST IS NECESSARY.

In 1964, the Monsanto Company developed a self-funded plan with minimal premium arrangements with Metropolitan Life. The State Insurance Commissioner of Missouri sued to enjoin Monsanto from engaging in the business of insurance. The case went to the State Supreme Court and that Court held that providing benefits to employees does not constitute the transaction of insurance business. This decision cleared the air from the insurance standpoint.

Section 514(B)(2) of ERISA pre-empts states from regulating self-funded plans under insurance banking and investment laws. This apparently removed any legal barrier to full self-funding. Several states have accepted this ruling, but at the present time, in Georgia, the situation on health benefit trust is not completely clear, although the state employees are self-insured at the present time.

BENEFITS OF SELF-FUNDING

1. Based on the experience of the other organizations who have formed a health benefit trust of employees and have chosen self-insurance, savings usually range between 15% and 35% depending on the program. An actual example is given below.

2. Reserves: Any interest that may accumulate from reserves or other available monies goes into the Trust instead of being lost to an Insurance Company.

3. Claims control procedure: This is a very important factor in keeping costs down. The Association could establish its own policies and procedures on a fair and equitable basis. An appeal mechanism could be a part of the program if desired. Also, the benefit package would be determined by the Association. When dealing with an Insurance Company, a previously tailored benefit package usually has to be accepted or rejected in toto.

4. Administration: The administration includes a number of operations: processing and payment of claims, maintenance of necessary records, accountabili-

ty of funds, administration of the Trust, and advice and related actuarial information necessary to the proper maintenance of the Trust.

5. Acquisition costs: This is probably the most important ingredient, simply because without member participation, there cannot be a program. This also is a cost that the Association would have that an employer would not, because our members would be scattered all over the state, while an employer's members would be in one location.

It is our belief that the administration can be more flexible and responsive when performed by an organization specifically designed for this purpose.

6. Premium tax: At this time, there is a 2% premium tax paid to the State of Georgia by all insurance companies. This tax is not required of a Trust.

The premium of an actual program cannot be presented at this time because a Trust must first be established. Therefore, the actual figures from two programs will be presented below. These programs were not singled out from a number of programs, but are the only programs for which accurate figures were available to us at this time. It may be of value to compare these figures with those of your present program.

PROGRAM I

Basic benefits: Hospital room and board limit $60.00 per day for 60 days.

Surgical expenses: Up to $1000.00

Medical benefits: $10.00 per day for 30 days

Laboratory and x-ray: Limit $200.00

Major Medical Benefits: Maximum $250,000.00 per life time, deductible $100.00, co-insurance 80%-20% on the first $5000.00, then 100% of remaining.

Costs:

$187,455.58	cost of insurance premium when not self-insured
$109 986.19	total self-insurance for one year
$77,459.39	savings—43%
382	average number of insured
$55.19	average insurance premium
$32.28	average self-insurance premium

PROGRAM II

Basic Benefits:

Surgical: Up to $1000.00, based on 1964 RVS unit $5.00

X-ray and Lab: $10.00 deductible up to $100.00

Excess charges in both eligible for Major Medical

Major Medical Benefits: $100.00 deductible per year (maximum 4 deductibles per family) 80-20% co-insurance to maximum of $250,000.00 per life time. Psychiatric—80% to maximum of $30.00 per treatment to a maximum of $1600.00 per year.

Costs:

$411,621.00	cost of insurance premium when not self-insured
$283,537.92	total self-insurance cost
$128,083.03	saving—31%
680	average number insured
$50.44	average insurance premium
$34.74	average self-insured premium

The cost for self-insurance for MAG members would be slightly higher because of acquisition costs. However, the saving would still be quite substantial. Life and disability benefits could be included in the program through arrangements with an insurance company.

RECOMMENDATION

It is recommended that the Executive Committee be instructed to form a Health Benefit Trust for the benefit of MAG members.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee read with great interest this comprehensive report from the Committee on Membership Insurance. Your reference committee would like to commend Dr. Mauldin and the other members of this committee for their outstanding effort.

Your reference committee recommends that this report not be adopted.

HOUSE OF DELEGATES ACTION—Voted that this report be not adopted.

REFERENCE COMMITTEE A

RESOLUTION 2
UNIFIED MEMBERSHIP

DeKalb Medical Society

WHEREAS, the membership of DeKalb Medical Society voted overwhelmingly to oppose the implementation of unified membership with the Medical Association of Georgia, and,

WHEREAS, membership in any level of organized medicine should be totally voluntary, and

WHEREAS, the enforcement of unified membership has caused much hostility and dissent within our membership at a time when enthusiasm, dedication, and commitment are much more important than forced unity; therefore, be it

RESOLVED, that the Medical Association of Georgia delay indefinitely implementation of its policy of unified membership pending further study.

RESOLUTION 20
REPEAL OF CHAPTER VIII, SECTION 2— UNIFIED MEMBERSHIP

Medical Association of Atlanta

WHEREAS, arguments for unification at the last House of Delegates meeting predicted possible small loss of members in county societies, and

WHEREAS, the last House of Delegates voted in favor of Unified Membership and the enforcement of this change thus far has produced in some county medical societies greater aggravation than expected, even threats of lawsuits, and has carried a higher rate of discord than projected a year ago, and

WHEREAS, in the Medical Association of Atlanta official resignations are increasing and current delinquency rate is 68% higher than at this time a year ago, and

WHEREAS, the goal should be to create and maintain harmony among our colleagues, now, therefore be it

RESOLVED that Section 2 of Chapter VIII entitled Unified Membership be repealed.

RESOLUTON 26
UNIFIED MEMBERSHIP

Bibb County Medical Society

WHEREAS, the Bibb County Medical Society is in agreement with the resolution presented by the DeKalb Medical Society concerning unified membership and referred to Reference Committee A; R: 2-77, be it therefore

RESOLVED, that the Bibb County Medical Society go on record as strongly supporting said resolution presented by the DeKalb Medical Society urging indefinite delay of implementation of unified membership.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee considered Resolution 2, 20 and 26 together since they related to unified membership. After careful consideration of these three resolutions as well as consideration of the reports of the 1976 Constitution and Bylaws Committee, which was adopted by the 1976 House of Delegates (Proceedings Issue of JMAG, June 1976, pages 256-257), your reference committee concluded that regardless of the action taken on these resolutions, unified membership is a constitutional policy of MAG and if indeed the membership desires otherwise, it will be necessary that the House of Delegates recommend that changes be made in the Constitution.

We therefore recommend that Resolutions 2, 20 and 26 not be adopted.

HOUSE OF DELEGATES ACTION—Voted that Resolutions 2, 20, and 26 be not adopted.

LIAISON COMMITTEE TO THE GEORGIA STATE MEDICAL ASSOCIATION (C25)

Ronald F. Galloway, M.D.

This represents my report to the 1977 House of Delegates of the Medical Association of Georgia as Chairman of the Medical Association of Georgia Liaison Committee to the Georgia State Medical Association.

Nothing has arisen during the past year to demand a formal meeting of this committee. However, in December 1976, I discussed relationships between the Medical Association of Georgia and the Georgia State Medical Association with Dr. Nelson McGhee of Atlanta, my Georgia State Medical Association Counterpart. Our discussion centered around three items: (a) The Georgia State Medical Association has requested additional representation on specialty panels for the purposes of peer review. Apparently, considerable dialogue between Dr. McGhee, Dr. A. M. Davis of Atlanta (President of the Georgia State Medical Association) and Dr. Earnest Atkins of our own Association has led to better understanding and substantial resolution of this particular matter.

(b) Concern over reduced payments by the Medicaid Program has apparently led the Georgia State Medical Association to seek better lines of communication with the Georgia Medical Care Foundation. Again, Dr. McGhee seemed to feel that much of this problem had also been resolved by various communications with officers of the Medical Association of Georgia and officers of the Georgia Medical Care Foundation. (c) One problem still exists and needs attention by the House of Delegates. The bylaw change passed by the 1976 House of Delegates of the Medical Association of Georgia makes MAG membership mandatory for membership in constituent County Medical Societies effective January 1, 1977. I'm uncertain that the House of Delegates had this intent, but, in passing this bylaw, the House of Delegates established policy which requires black physicians in Georgia who are members of County Medical Societies and their own Georgia State Medical Association of Georgia to belong to and pay dues to the Medical Association of Georgia as well if they are to maintain membership in the local County Society after January 1, 1977. Therefore, I make the following recommendation:

RECOMMENDATION

That the House of Delegates of the Medical Association of Georgia consider the rationale of accepting membership in the Georgia State Medical Association as a satisfactory requirement for membership in constituent County Medical Societies in Georgia.

REFERENCE COMMITTEE RECOMMENDATION —This report recommends that the House of Delegates consider the rationale of accepting membership in the Georgia State Medical Association to satisfy the requirements for membership in constituent county medical societies of the Medical Association of Georgia.

Your reference committee recommends that this recommendation not be adopted.

HOUSE OF DELEGATES ACTION—Voted that the Recommendation contained in this report be not adopted. Delegate James Kaufmann then moved the adoption of an amendment by addition of the following to the reference committee recommendation on this report, "and we further recommend that MAG Staff be directed to give top priority to the recruitment of new members and retaining those members already in the County Society." This Amendment was adopted.

FIRST DISTRICT COUNCILOR (O/C13)

Leon E. Curry, M.D.

In the First District we have witnessed an increase in the number of physician members of the First District Medical Society and the MAG. We have also witnessed an increase in participation of individual members in the activities of organized medicine. Our annual First District Medical Society meeting is well attended and has become a significant scientific meeting as well as a very pleasurable social affair beginning with athletic competition in the morning, scientific papers in the afternoon, a business meeting in the early evening followed by dinner and a nationally recognized after dinner speaker.

This annual event brings together well over one hundred people which strengthens organized medicine. It also enlightens individual physicians regarding matters of mutual concern to all private practice physicians. We continue to strongly support the idea of well-organized district medical societies as well as county medical societies.

Reports from presidents of component county medical societies indicate a feeling among physicians of apprehension with regard to Public Law 93-641, otherwise known as the Health Services Act.

Physicians view this HSA as the beginning of socialized medicine and are deeply concerned about the consequences which are far-reaching.

Having been involved with activities of the ad hoc committee for Primary Care Planning in the VII HSA area, I can attest to the faltering confusion and bureaucratic blunders of this newly organized governmental agency. It is my observation that the Board of Directors and the committees thus far established have progressed little, if any at all, in their overall health care plan preparation.

The consumer-dominated board and committees are encumbered by the necessity for racial, geographic and consumer/provider ratios which must by law be followed.

For a meaningful plan to be developed more professional health care planners must be involved and the input of organized medicine *must* be obtained. Unfortunately, the activities of the HSA's are not well publicized to physicians nor to the lay public. It is incredible to me that such an all encompassing law is on the books and yet many physicians and most of the lay public are totally unaware of its existence and its consequences.

A number of foreign trained physicians are now practicing within the First District who are not members of the First District Medical Society or MAG. This is true particularly of Liberty County, Tattnall and Evans County. Attempts are underway to invite them to join.

Physicians Assistants in the First District in both primary care and specialty areas have been well accepted throughout this district and no problems have been reported thus far relative to their activities. Vigilance is being maintained to assure their continued competence and integrity.

In general I must report that organized medicine in the First District remains solidly behind the concept of private practice, the free enterprise system, and minimal governmental intrusion and regulation, which is probably true throughout the United States.

The members of the First District applaud the efforts and achievements of the leadership of the Medical Association of Georgia and thank them for their valuable contribution to the continued delivery of quality health care to the citizens of Georgia.

MEMBERSHIP

Counties and Secretaries	Members December 31, 1975 MAG	Members December 31, 1975 AMA Dues Paying	Members December 31, 1976 MAG	Members December 31, 1976 AMA Dues Paying
Ogeechee River				
Frank D. Glenn				
Statesboro	26	24	30	27
Burke				
Walter R. Voyles				
Waynesboro	5	5	4	4
Emanuel				
James L. Ray				
Swainsboro	5	5	5	5
Laurens				
Grady E. Longino				
Dublin	31	25	30	22
Screven				
Nicki Schuman				
Sylvania	4	4	5	5
Southeast Georgia				
Ralph Perkerson				
Vidalia	10	9	10	8
St. John's Parish				
Ruben Silan				
Hinesville	6	6	8	1
	87	78	92	72

REFERENCE COMMITTEE A

REFERENCE COMMITTEE RECOMMENDATION—The report of the First District Councilor was referred to Reference Committee A without recommendations to call attention to the statement on Health Systems Agencies. This was reviewed and found to be quite predictable.

We recommend that the report from the First District Councilor be filed.

HOUSE OF DELEGATES ACTION—Report filed.

COMMITTEE ON COMMUNICATIONS (C7)

Marvyn D. Cohen, M.D.

The Association's communication efforts continue to show positive results. These gains have been made generally at the staff level under the direction of the committee and MAG leadership.

Again, a highlight of our year was the positive response to our third issuance of public service radio announcements. These 30-second spots were supplied to all radio stations in the state. Of the 220 stations that received the spots, 80 responded to a "projected usage" card that was enclosed. Such comments as "appeals to all ages," and "helpful to the public," were typical of comments from station program directors. The spots were scripted and production was directed by Charlie Templeton, MAG's Director of Public Relations.

The MAGNET Conference was held in Atlanta and considered a success. The program centered on the more effective use of practice management techniques to improve the quality of care. The whole area of the socioeconomics of medicine is playing an ever-increasing role in the delivery of care and MAG should continue its leadership role in this area.

Three years ago the Communications Committee requested funds to provide refreshments to physicians taking the FLEX Examination in Atlanta. This expenditure has proved most valuable, both in identifying potential new members and building a stronger relationship with the State Composite Board of Medical Examiners.

Media relations continue to be an important aspect of Association communications activity. We were asked

many times during 1976 by both print and broadcast media to assist with articles, interviews and programs. Additionally, our Director of Public and Professional Relations made several trips for direct contacts with key media personnel throughout the state. Your Chairman was able to support this activity in the Columbus area, assisting in the scheduling of articles and interviews. We are pleased to report that MAG is now sought out for assistance by the media instead of only being allowed to respond after the fact.

The Committee Chairman was privileged to attend the AMA Leadership Conference during the year. This meeting is extremely valuable to persons in medical society positions.

RECOMMENDATIONS

1. That the Committee be given approval to develop and present a comprehensive package of socioeconomic programs for the membership. That such a package should be presented to the Executive Committee for approval and funding if needed.
2. That MAGNET continue in its current broad interest format with funding adequate to meet expenses.
3. That the radio public service program be continued in accordance with Association policy.
4. That the services of the MAG communications team be made known to component county medical societies for the purpose of developing local public relations programs.
5. That the public relations chairman of the MAG Auxiliary be made a liaison member of the Communications Committee.
6. Further recommended that a representative from the Physician's Assistants Association and the Association for Medical Assistants be added as liaison members. These groups have been highly supportive of the MAGNET Conference and can be helpful in achieving other Association goals.
7. That the Committee be given approval to develop and produce a "how to" public relations booklet for use by county medical societies. The booklet would contain suggested PR programs, new member orientation programs, etc.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee recommends that Recommendations 1, 2, 3, 4, 5 and 7 be adopted. Your reference committee recommends that Recommendation 6 be not adopted.

HOUSE OF DELEGATES ACTION—Voted to adopt Recommendations 1, 2, 3, 4, 5 and 7 of the committee report and voted that Recommendation 6 of the committee report be not adopted.

RESOLUTION 33
MEDICAL ETHICS

W. Dan Jordan, M.D.
Medical Association of Atlanta

WHEREAS, ethical standards cannot be legislated, and

WHEREAS, ethical standards of physicians can and should be judged only by their colleagues, and

WHEREAS, physicians carry an obligation to expose unethical conduct on the part of another physician (see Sec. 4 of Code of Ethics), therefore be it

RESOLVED, that the House of Delegates of the Medical Association of Georgia establish policy of tightening ethical standards of its members so as to impress upon the public its ability and desire to maintain the highest ethics of the practice of medicine, and be it further

RESOLVED, that the House of Delegates of MAG encourage its component county societies to contribute their efforts to police their members so that membership in organized medicine will be viewed as the epitome of the ethical practice of medicine.

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee recommends adoption of this resolution.

HOUSE OF DELEGATES ACTION—Adopted Resolution 33.

RESOLUTION 34
LABORATORY CHARGES

W. Daniel Jordan, M.D.
Medical Association of Atlanta

WHEREAS, both the public and the medical community are concerned about the continuing rise of medical care costs, and

WHEREAS, the incidents of high laboratory charges have been cited as examples of fraudulent activity and as being contributory to high medical care costs, and

WHEREAS, the AMA Judicial Council has issued a statement declaring mark-up, commission, or profits taken by attending physicians to be exploitation of the patient (see Report 6C-77), therefore be it

RESOLVED that the House of Delegates of MAG declare that the attending physician be entitled to fair compensation for the professional services that he renders, but that any mark-up, commission, or profit on services rendered by a laboratory is exploitation and is, therefore, unethical.

REFERENCE COMMITTEE RECOMMENDATION —This resolution deals with the physician's relationship to laboratory charges.

Your reference committee recommends that Resolution 34 be not adopted, as the issue has been previously acted upon in the report from Reference Committee D which states, "that MAG go on record as deploring any fees for laboratory services not justified by cost and service rendered."

HOUSE OF DELEGATES ACTION—Voted that Resolution 34 be not adopted.

OFFICE OF THE SECOND VICE PRESIDENT (O/C5)

Milton I. Johnson, M.D.

Your Second Vice President attended all the Executive Committee and Council meetings, save one, that were held within the state.

The past year has been both interesting and informative for your Second Vice President. I continue to be impressed by the almost overwhelming amount of business that the Executive Committee and Council must deal with. We seem at times to live from crisis to crisis. It appears that if the state and federal governments cannot suppress us fast enough by regulation, they plan to simply wear us down.

Equally impressive is the dedication of Committee Members, Council Members and Officers, spending the long hours needed to keep our ship afloat and pointed somewhere.

It seems to me that over the years, the MAG has become over-organized. I think we should stop and be sure our priorities are in order, that we thrust in the right direction and not decrease our effectiveness by going off in all directions at once.

RECOMMENDATION

To this end, I would recommend that consideration be given to getting an outside firm that is knowledgeable in this area to review our Association's officer, committee and administrative structure with the idea of making our organization more efficient.

Another troublesome area to me is the Association's seeming lack of a firm basic policy in many of the areas regarding government encroachment on medicine. This is in spite of a book full of published MAG policy statements on many issues. For example, one year the House of Delegates voted that participation in PSRO was unethical and the next year reversed that decision.

We must all stand firmly together and maintain our honor and perform our duty of protecting the public from socialization of medical care.

Even if we fail with this approach, our honor will be untarnished, but if we continue to indulge in pragmatism, we shall surely lose and have nothing left but a sense of frustration and pathos.

I appreciate the high honor and privilege of serving as your Second Vice President and look forward to serving you next year.

RESOLUTION 32
ASSOCIATION FINANCES

C. O. Sennett, M.D.
Floyd-Polk-Chattooga County Medical Society

WHEREAS, the operating budget of the Medical Association of Georgia has increased disproportionately to the quality and quantity of services being rendered to the membership (expenses for FY70-71 was $260,-653.37 and the budget for 1976-78 is $936,800, which represents an inrcrease of over 300% over the eight year period), and

WHEREAS, there has been concern expressed by many MAG members as to whether they are getting sufficient return on their dues dollar, and

WHEREAS, these concerns raise serious question as to the efficiency of the staff, Council and its Executive Committee in managing the fiscal affairs of the Association, therefore be it

RESOLVED, that the House of Delegates establish a special committee to conduct an extensive audit of every phase of the Association to determine if the finances are being properly managed, and be it further

RESOLVED, that this special committee report its findings to the 1978 MAG House of Delegates, as well as keep Council and its Executive Committee apprised of its activities.

RESOLUTION 35
INVESTIGATION OF MAG ORGANIZATION

W. Dan Jordan, M.D.
Medical Association of Atlanta

WHEREAS, there have been serious allegations concerning the day-to-day activities centering around the headquarters office of MAG, therefore be it

RESOLVED that the House of Delegates of MAG directs an in-depth investigation of organizational aspects of the association and its staff to determine their efficiency and effectiveness, and be it further

RESOLVED, that this investigation be carried out by a committee of the House of Delegates with a full report to be made to the 1978 House of Delegates.

REFERENCE COMMITTEE A

REFERENCE COMMITTEE RECOMMENDATION —Your reference committee considered together these reports and resolutions concerning the MAG organization and function. Many hours were spent in open and closed session discussing the ramifications of these reports.

Numerous individuals were interviewed reflecting attitudes on both sides of the question.

Investigations of specific allegations outlined in closed sessions failed to convince committee members that these events resulted from anything more than errors in judgment.

As a result, your reference committee recommends that the report of the Second Vice President be not adopted and that Resolutions 32 and 35 be not adopted.

Your reference committee further recommends that a committee of the House be appointed by the Speaker of the House and the President of MAG and be charged with the task of performing an internal review followed by an external review similar to that done recently for the Georgia Medical Care Foundation by Dr. John McCain.

It is further recommended that this committee report to the House of Delegates in 1978, but in the interim, it may report to the Council if action is necessary before that time.

HOUSE OF DELEGATES ACTION—Voted that the report of the Second Vice President and Resolutions 32 and 35 be not adopted.

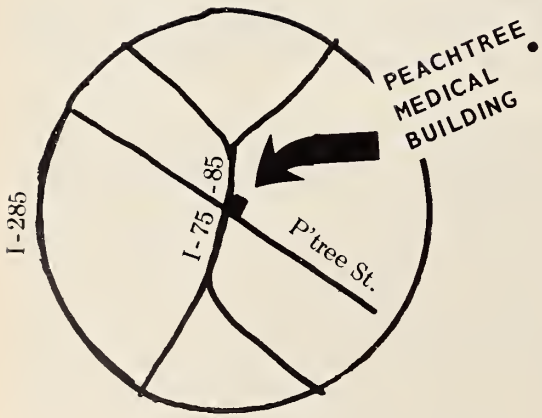
The House concurred in a further recommendation of the reference committee that a committee of the House be appointed by the Speaker of the House of Delegates and the President of MAG and be charged with the task of performing an internal review followed by an external review similar to that done recently for the Georgia Medical Care Foundation by Dr. John McCain. The House further concurred that the committee report to the House of Delegates in 1978 but in the interim it may report to the Council if action is necessary before that time.

Chairman Oliver thanked the members who served on the reference committee and those who appeared before the committee, stating that their views were quite valuable to the committee in its deliberations. He also thanked the Staff for their assistance.

FOR LEASE



PEACHTREE MEDICAL BUILDING
401 Peachtree St., N. E., Atlanta, Georgia 30308



- Not to be affected by Marta Construction
- Custom Designed Medical or Dental Suites.
- Individual Control of Heat and Air Conditioning.
- Convenient "On the Premises" Parking for Tenants and Patients.
- Public Transportation at Front Door - Convenient to Major Thoroughfares and Expressways.
- Quality Building – Owned by Physicians and Dentists.
- Close Proximity to Four Major Hospitals.
- In-house Management
- $7.00 per sq. ft., including utilities and janitorial services.

J. C. LINDSEY REALTY COMPANY

SUITE 114 PEACHTREE MEDICAL BUILDING

401 PEACHTREE STREET, N. E. – ATLANTA, GEORGIA 30308

PHONE (404) 525-4621

Delegate Jack Raines from Columbus was recognized and moved that the House give a standing vote of commendation to our departing Vice Speaker and our in-coming Speaker for their aid in the proceedings of this House. It was so adopted.



ELECTION RESULTS

The Speaker relinquished the Chair to Dr. Fleming Jolley, President of the Association, for the purpose of announcing the results of the elections. Having received the results of the elections from the Teller's Committee, Dr. Jolley announced the results as follows: President-Elect—Carson Burgstiner, 141; C. E. Bohler, 1; Donald Duck, 1. Second Vice President—L. Newton Turk III, 142; Kenneth McDonald, 1. Treasurer—James H. Sullivan, 142; W. Daniel Jordan, 1. Speaker—L. C. Buchanan, 110; F. W. Dowda, 32; Ronald Galloway, 1. Vice Speaker—Jack Menendez, 142; Ronald Galloway, 1. AMA Delegate—C. E. Bohler, 143; F. William Dowda, 141; Luther Vinton, 2. AMA Alternate Delegate—F. G. Eldridge, 143; Charles Hollis, 142; J. Daniel Bateman, 1.

ADJOURNMENT

On motion duly made and seconded, the House of Delegates adjourned the final session at 1:15 p.m. The Speaker then immediately turned the gavel over to Fleming L. Jolley, M.D., President of MAG, for the purpose of presiding over the final General Session.



Dr. James Skinner congratulates Dr. Carson B. Burgstiner on his election as President-Elect of MAG.

NCR Interactive Healthcare Information System

Comprehensive Recordkeeping and Accounting for Clinics



The NCR Interactive Healthcare Information System consists of six integrated applications that can be tailored in any combination to handle the patient-processing and general accounting needs for all clinics.

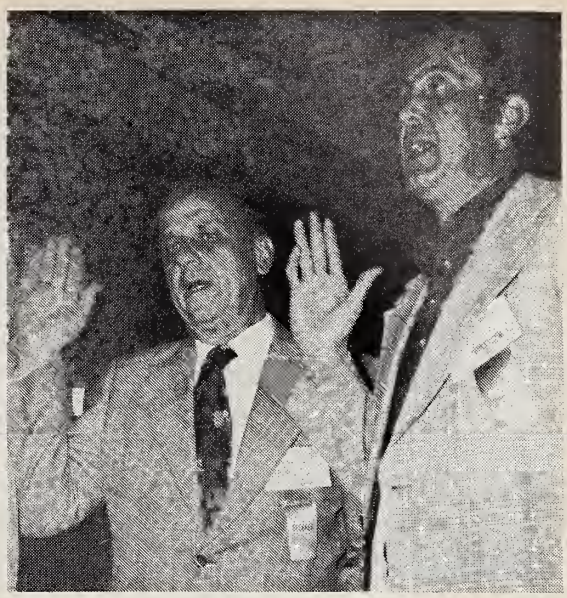
- IHIS is an interactive, online system. Data is entered through CRT display terminals and updates all affected files in one pass—automatically and instantaneously.
- IHIS is a real-time system. You get the information you need RIGHT NOW —when you need it—not tomorrow or at the end of the month's processing cycle.
- IHIS is a multiprogramming system. Up to seven separate data entry or inquiry operations can be serviced simultaneously—even requests for printed reports or forms.
- IHIS is a simple, virtually foolproof system—a system that uses a question and answer method to guide you through data entry or to the exact information you need. It's a system that protects your files by requiring password authorization, by checking every entry for correct format and type of content, by providing you with printed audit trials and control totals for every transaction that takes place.
- Best of all, IHIS is a turnkey system. You tell NCR systems analysts what your requirements are; they CUSTOM TAILOR applications and files to meet those requirements.

Contact NCR for information on the IHIS and the many other systems available for hospitals, clinics and individual practices.

NCR
Complete Computer Systems

5 Executive Park Drive
Atlanta, Georgia 30329
Telephone: (404) 634-1541





Taking the oath of office: Dr. Robert E. Perry Jr., Dr. Joe C. Stubbs, Dr. F. W. Dowda, Dr. Carson B. Burgstiner, Dr. James H. Sullivan, Dr. L. C. Buchanan, Dr. E. M. Molner.

MAG Final General Session

Sunday, April 24, 1977

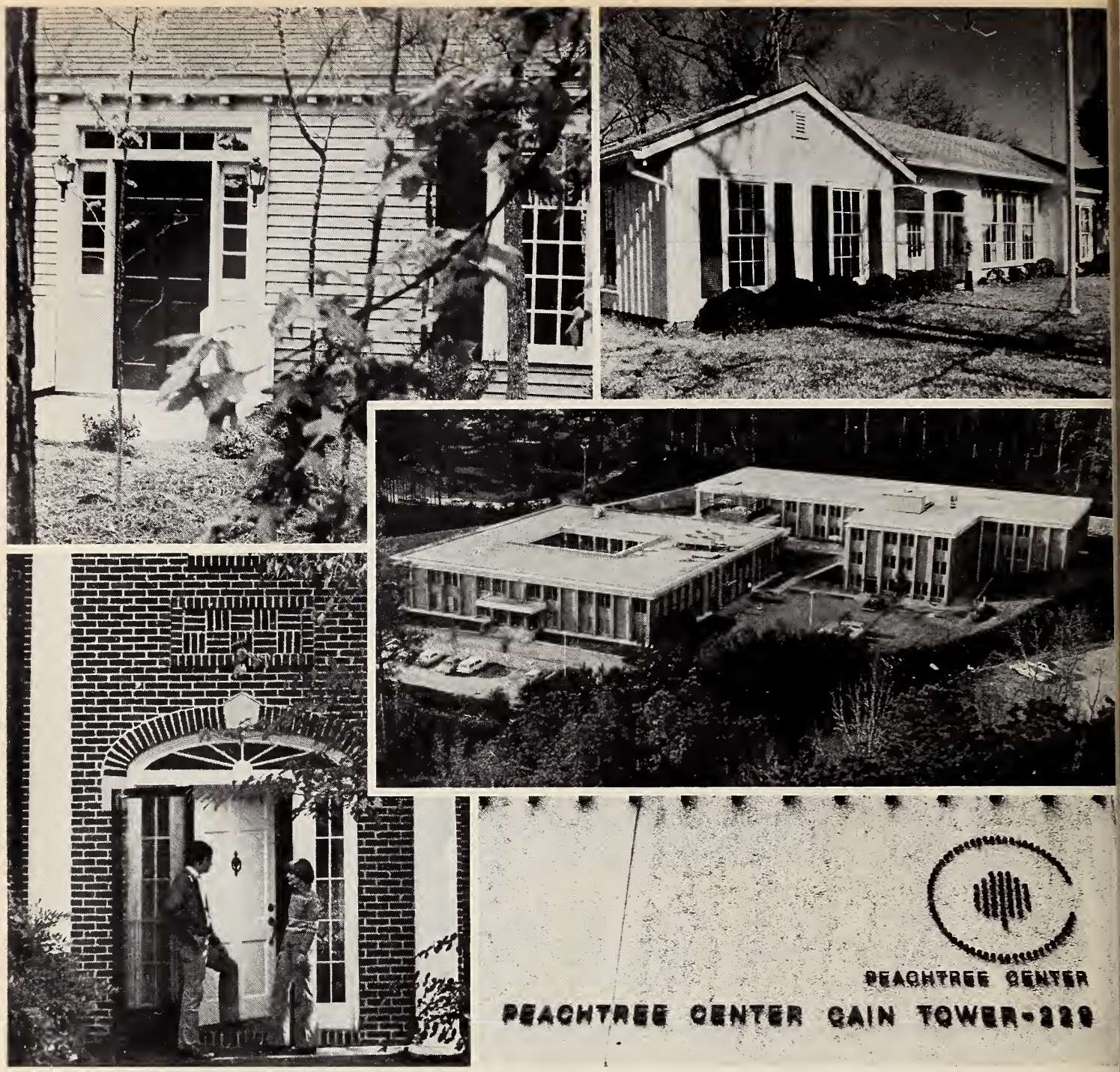
President Jolley convened the final session of the 1977 Annual Session Business Meeting and expressed his appreciation to Doctors Buchanan and Galloway for their handling of the business of the House of Delegates.

Installation of Officers

Dr. Jolley asked the in-coming President, the other Officers of the Association, the AMA Delegates and Alternates, Directors and Alternate Directors, to assemble in front of the Speaker's platform for the purpose of taking the Oath of Office, as follows:

President
Robert E. Perry Jr., Brunswick (1978)
President-Elect
Carson B. Burgstiner, Savannah (1978)
Second Vice President
L. Newton Turk III, Atlanta (1978)
Speaker of the House
L. C. Buchanan, Decatur (1980)
Vice Speaker of the House
Jack Menendez, Macon (1980)
AMA Delegate
C. E. Bohler, Brooklet (1980)
AMA Delegate
F. William Dowda, Atlanta (1980)
AMA Alternate
F. G. Eldridge, Valdosta (1980)
AMA Alternate
Charles D. Hollis, Albany (1980)
Sixth District Director
James M. Skinner, Griffin (1980)
Sixth District Alternate Director
Norman P. Gardner, Thomaston (1980)
Seventh District Director
Richard A. Griffin III, Cartersville (1980)
Seventh District Alternate Director
D. R. Mahan Jr., Dalton (1980)
Eighth District Director
Joe C. Stubbs, Valdosta (1980)
Eighth District Alternate Director
Michel A. Glucksman, Brunswick (1980)
Medical Association of Atlanta Director
John P. Godwin, Atlanta (1980)
Medical Association of Atlanta Alternate Director
J. Norman Berry, Sandy Springs (1980)
Muscogee County Medical Society Director
Jack A. Raines, Columbus (1980)
Muscogee County Medical Society Alternate Director
E. M. Molnar, Columbus (1980)
Bibb County Medical Society Director
Beverly B. Sanders Jr., Macon (1978)
Bibb County Medical Society Alternate Director
Rodney M. Browne, Macon (1978)

President Jolley administered the Oath of Office to the assembled new officers of MAG and declared



PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD
Mental Health Center and Hospitals
1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431
Accredited by the Joint Commission on Accreditation of Hospitals

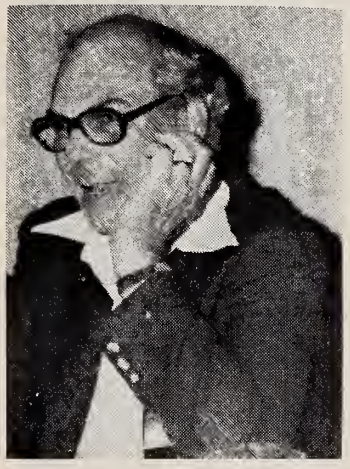
each of these officers duly installed.

Dr. Jolley then presented Certificates of Appreciation to Ronald Galloway, M.D., Jack Menendez, M.D., Frank Miller, M.D., Milton I. Johnson, M.D., James H. Sullivan, M.D., W. D. Logan, M.D., and Jack A. Raines, M.D.

Dr. Jolley then passed the gavel, the symbol of leadership, over to the in-coming President, Robert E. Perry, who expressed his appreciation for the honor of being elected President for the year 1977-78. Dr. Perry then presented to Dr. Jolley the President's key and the bound volume of the issues of the *Journal of the Medical Association of Georgia* published during Dr. Jolley's term of office.

Dr. Perry announced the date and site of the MAG Annual Session, House of Delegates meetings for the following three years as follows:

1978—Jekyll Island—April 14, 15, 16
1979—Savannah—April 20, 21, 22
1980—Atlanta—April 25, 26, 27



Dr. Perry announced the official attendance at the 123rd Annual Session as follows:

Delegates	168
Alternate Delegates	17
Members	92
Guests	35
Auxiliary	172
Total Registration	484

Got a knack for public speaking?
Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at **(404) 876-7535; INWATS (800) 282-0224.**

Capital Cadillac

SELLS AND LEASES
CADILLACS
FOR LESS THAN
ANY OTHER DEALER
IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

Invest in Rare Silver

Rare medallic history of the United States. 200 large solid sterling silver medals, each with history of a different year. Over 8 years to assemble and complete.

Each medal is individually hallmarked to certify that it is solid sterling silver. Each medal of this rare First Edition Proof Set has serial number which will be registered in your name to provide excellent protection. One of only a relatively few sets minted in this brilliant Proof condition.

Special purchase price. Purchase now and receive valuable bonus collection. For information, call

261-4902

editorials
editorials
editorials

Election of MAG Officers



Dr. James H. Sullivan, Mrs. Bunny Sullivan, Mrs. Jaquie Burgstiner and Dr. Carson B. Burgstiner.

ONE OF THE HIGHLIGHTS of each Annual Session is the election and installation of officers for the Association. The following are short sketches of your Association officers for the year 1977-78.

The information is, of course, not a complete accounting of these individuals' activities and professional credits; however, it will afford members the opportunity to appreciate the highly qualified individuals that will lead them throughout the year.

President

Robert E. Perry Jr., M.D., a native of Sylvania, Ga., is currently the Associate Director of the Pathology Laboratory at the Glynn-Brunswick Memorial Hospital. A graduate of the Medical College of Georgia, Dr. Perry has been president of the South Georgia Medical Society, president of the Eighth District Medical Society and chairman of the MAG Council.

President-Elect

Carson B. Burgstiner, M.D., is a native of Okeechobee, Fla., and a graduate of the University of Miami School of Medicine. He is currently in a group practice of obstetrics and gynecology in Savannah.

First Vice President

Milton I. Johnson, M.D., a native of Macon, is a graduate pharmacist as well as having received a medical degree from the Medical College of Georgia. Dr. Johnson has held several offices in the Georgia Academy of Family Physicians and the MAG. He has been vice councilor, councilor and a member of the House of Delegates from Bibb County. He has a solo practice of family medicine in Macon.

Second Vice President

L. Newton Turk III, M.D., is a specialist in cardiovascular and thoracic surgery in Atlanta and is a native of that city. He is a graduate of the Emory School of Medicine and has been quite active in medical society activities. Dr. Turk has been treasurer, chairman of the board of trustees, president and a delegate of the Medical Association of Atlanta. Dr. Turk is in a group practice.

Secretary

Earnest C. Atkins, M.D., is originally from Marietta and is a graduate of the Emory School of Medicine. He is an active member of the DeKalb Medical Society and has served as president of that society. Dr. Atkins has been treasurer and state chairman of GaMPAC. He is a solo practitioner in general surgery in Decatur.

Treasurer

James H. Sullivan, M.D., is also a graduate pharmacist in addition to having graduated from the Medical College of Georgia. He is a native of Green Mountain, N.C. Dr. Sullivan has served organized medicine as president and delegate for the Muscogee County Medical Society and as second and first vice president of MAG. Dr. Sullivan is in group practice af urology in Columbus.

Speaker of the House

L. C. Buchanan, M.D., is a native of DeKalb County and a solo practitioner in general surgery in Decatur. He is a graduate of the Emory School of Medicine. Dr. Buchanan is a past president of the DeKalb Medical Society, past president of the Fifth District Medical Society, member of the board of directors, vice president of the Georgia Medical Foundation and a delegate to the MAG House.

Vice Speaker of the House

Jack F. Menendez, M.D., is a native of Daytona Beach, Florida and a graduate of the Emory School of Medicine. He is a past president of the Bibb County Medical Society and has also served his society as an alternate delegate and then as a delegate to the MAG House. Dr. Menendez is a past medical director

MEDICAL ASSOCIATION OF GEORGIA
Education Division

1977 MAG SCIENTIFIC ASSEMBLY

at the exciting

OMNI INTERNATIONAL HOTEL
Downtown Atlanta

November 17-20, 1977

MARK YOUR CALENDAR NOW . . .

for a pleasurable experience in continuing medical education

- **Scientific programs in 16 specialties:** Allergy and Immunology; Emergency Medicine; Gastroenterology; Internal Medicine; Neurology; Neurosurgery; Nuclear Medicine; Ophthalmology; Pathology; Pediatrics; Plastic Surgery; Public Health; Psychiatry; Radiology; Surgery; Chest.
- **Interdisciplinary program in Asthma**
- **AMA Category 1 credit for all programs**
- **Luncheon and plenary session with a nationally-known guest speaker**
- **Scientific exhibits**
- **Alumni night**

MAG Members Will Receive a Flyer and Registration Form in the Late Summer Giving Full Details

of the Georgia Medical Care Foundation and is currently president of the Foundation. He has a group practice of general surgery in Macon.

Chairman of the Board of Directors

Joe C. Stubbs, M.D., is a graduate of the Emory School of Medicine and in the private practice of internal medicine in Valdosta. Dr. Stubbs is a native of Jacksonville, Florida. He has been president of the South Georgia Medical Society and served the MAG as a vice-councilor.

Vice Chairman of the Board of Directors

Jack A. Raines, M.D., a native of Shelby, N.C., is a graduate of the University of Tennessee School of Medicine. He has served as a councilor and delegate to the House from Muscogee County. Dr. Raines is currently practicing in Columbus, specializing in psychiatry.

Corrections of May Editorial

Several typographical errors sneaked by our not-so-watchful eyes last month. The fourth and fifth paragraphs of Dr. Woody's editorial, page 312 of the May issue, should *read as follows:*

These arbitrary ideas largely ignore the basic mechanisms underlying increased health costs. Increased costs throughout our economy are but a reflection of the general inflation **perpetuated** by increased deficit budgeting in our government. Only responsible restraint by the people we send to Washington to represent us can begin to halt this trend. The politician who promises the **uninformed** citizen more services from his government without apprising him of the economic consequences of deficit spending and spiraling inflation can only be guilty of a cruel hoax against the American people in order to perpetuate himself in office. The future of our economy is jeopardized by these "free lunch counter" pitchmen.

There is a well-recognized, increasing demand for **over utilization** of pre-paid medical insurance. This urge seems to stem from such logic as "If I've paid for it I want to use it" or "I've paid into Social Security all these years and I deserve it." These attitudes are particularly crucial in a hospital environment where increasingly sophisticated, expensive, and well-publicized diagnostic tools are becoming available. Increased malpractice suits with their escalating influence on medical costs through the practice of defensive medicine constitutes a significant factor. Responsible restraint on the part of the physician in situations like this can help to hold the lid on costs. It is hoped that more reliance on sound clinical judgment rather than blind faith in machines may become more acceptable to patients.

In the Addendum on page 286 of the May issue, part of the House action was inadvertently omitted. For a complete report on actions involving the Committee on Cost Accountability, please see page 412 of this issue.

president's letter



Annual Session Successful

THIS ISSUE of the *Journal* is devoted to the actions of the House of Delegates and your Association at the Annual Session held in Macon, Georgia, April 22-24 this year. There were 168 delegates, 17 alternate delegates, 92 members, 35 guests, and 172 Auxiliary members registered. Forty-eight county medical societies were represented.

The actions of the House of Delegates and its decisions are recorded in this issue. Perhaps the most important directive given by the House was the decision to conduct an internal survey of the operations of your Association with the view to improving operating efficiency as well as economic operations of all of your programs. I think it is, indeed, fitting that such be done.

I am sorry that more of you could not be present to witness the dedication of your delegates and members of the Reference Committees and the Herculean efforts of our staff at this most successful convention. Try to come next year.

Sincerely,

Robert E. Perry Jr. M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia

RURAL STUDENT PROJECT NEEDS PHYSICIAN VOLUNTEERS

The Georgia Student Health Association, an organization of Emory and Medical College of Georgia students, will be conducting health fairs in rural areas of the state this summer. Activities will include health education, laboratory tests, and physical examinations.

The students need physicians to provide supervision and teaching. Any amount of volunteer time, from one day to two weeks, will be welcomed. Dates and places are: June 27-July 9, Mitchell and Jones Counties; July 8-July 30, Murray and Burke counties.

To volunteer, or for further information, call Dan Blumenthal, M.D., **(404) 761-7121** or Stacy Fisher, student coordinator, **(404) 634-0831.** Malpractice insurance provided.

Got a knack for public speaking? Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at **(404) 876-7535; INWATS (800) 282-0224.**

WHAT ARE YOUR OBSERVATIONS

on pre-hospital care and emergency room care? What have you observed about Emergency Medical Technicians? Do you have ideas for how emergency services can be approved?
The EMS Newsletter would like to publish your 250-500-word articles on this subject. Submit any contributions you may have to:
EMS Newsletter Editor
Emergency Health Section
618 Ponce de Leon Ave.
Atlanta, Ga. 30308 Or Call (404) 894-5170

Do you have patients with Paget's Disease of Bone?



You can get updated information on the disease and on effective treatment for its symptoms of bone pain, skeletal deformities, and neurologic deficits.

Just send the coupon below.

Armour Pharmaceutical Company
Greyhound Tower
111 West Clarendon Avenue
Phoenix, Arizona 85077

☐ Send latest information on Paget's Disease of Bone.
☐ Have your representative call on me.

Dr. _____

Address _____

City _____ State _____ Zip _____

Preferred Partnerships inc.



RE: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Mr;

How much income tax are you now paying? We can help you shelter a portion of your present income---plus show you how you can receive Tax-Free income.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that give you a 4-to-1 or better write-off. We have investments in the $5,000 - $8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

NEW MEMBERS

Albea, John M., MAA—Act—P
281 Boulevard, NE, Atlanta 30312

Andrews, H. Gibbs, DeKalb—Act—Pd
5675 Peachtree-Dunwoody Rd., Atlanta 30342

Ansley, Joseph D., DeKalb—Act—Su
1365 Clifton Rd., NE, Atlanta 30322

Barfield, Randall W., MAA—Act—Pd
47 Peachtree Park Dr., NW, Atlanta 30309

Barnett, Stephen M., MAA—A—Su
1455 Ponce de Leon Ave., NE, Atlanta 30307

Burton, Joseph L., MAA—Act—Path
50 Coca Cola Place, SE, Atlanta 30303

Cafoncelli, Antonio R., Muscogee—Act—TS
202 Doctors Building, Columbus 31901

Chambers, Russell C., MAA—Act—I
575 West Peachtree St., NE, Atlanta 30308

Golden, Terry D., MAA—Act—I
1938 Peachtree Rd., NW, Atlanta 30309

Gotlieb, Edward M., DeKalb—Act
5565-D Memorial Dr., Stone Mountain 30083

Gotlieb, Jacqueline, DeKalb—Act—Pd
5565-D Memorial Dr., Stone Mountain 30083

Greene, David, MAA—Act—R
35 Linden Ave., NE, Atlanta 30308

Hassinger, John T., DeKalb—Act—Su
497 Winn Way, Suite A-130, Decatur 30030

Haysman, Melvin L., GMS—Act—Al
5105 Paulsen St., Savannah 31405

Jenkins, Charles A., Flint—Act—I
301 11th Ave., Cordele 31015

Johnson, Robert H. Jr., Richmond—Act—Su
Medical College of Georgia, Augusta 30902

Krone, Howard B., DeKalb—Act—Or
2754 North Decatur Rd., Decatur 30033

Manus, William A., Hall—Act—FP
242 Enota Dr., NE, Gainesville 30501

McElhannon, Fayette M. Jr., CWL—Act—Or
700 Oglethorpe Ave., Athens 30601

Peng, Vincent T., DeKalb—Act—D
4230 Indian Forest Rd., Stone Mountain 30083

Pollock, Richard A., MAA—Act—Oto
144 Ponce de Leon Ave., NE, Atlanta 30308

Sanders, Herbert F., GMS—Act—N
4 Jackson Boulevard, Savannah 31406

Talley, William Steele, MAA—A—PH
4770 N. Peachtree Rd., Atlanta 30341

Tift, William L., Bibb—Act—Pd
2009 Vineville Ave., Macon 31204

Wheeler, James H., DeKalb—Act—FP
4555 N. Shallowford Rd., Atlanta 30341

Wier, Marion A., Richmond—Act—R
Medical College of Georgia, Augusta 30902

Wigh, Russell E., Richmond—Act—R
Medical College of Georgia, Augusta 30902

SOCIETIES

In April, Drs. Jack Menendez, Hugh Smisson, Alex Weaver, Charlie Duggan, Rodney Browne, Hugh Sealy and Ed Watson of the **Bibb County Medical Society** met with the editors of the *Macon Telegraph* for off-the-record chats. Everyone felt that a good rapport was set up between the society and the press and expressed hope that similar meetings would be held in the future.

The May meeting of the **Bibb County** society was its annual Medicine and Religion Program, featuring a discussion on "Comforting the Sick and Their Families."

The April meeting of the **DeKalb Medical Society** featured discussion with Fourth District Congressman Elliott Levitas.

Representatives from **DeKalb,** Drs. Lamar McGinnis, Elliott Moon, John Head and Stan Aldridge and Executive Director Hank Holderfield met with their county's school superintendent Jim Hinson to initiate effort for a comprehensive health education program in the schools. Many suggestions were made by the society and members are waiting for positive response from the schools.

DEATHS

Jordan Eli Billings

Jordan Eli Billings, past president of the Gordon County Medical Society, died January 8 at the age of 77.

Dr. Billings, who was born in North Carolina, attended Appalachia State University and was a graduate of Berea College. He did his post graduate work at Emory University and the University of Georgia and was graduated from the Medical College of Georgia. His internship was done at Georgia Baptist Hospital in Atlanta.

He began his medical practice in Fairmount, moving to Calhoun seven years later, where he became a member of the staff of Johnston-Hall Hospital. He later became co-owner of that hospital.

Dr. Billings served his community as a member of the Fairmount Board of Education, the Calhoun City Board of Education and the Welfare Board of Gordon County. He was chief examiner of the local draft board and served as the chief of the medical staff of Gordon County Hospital.

INCOME PROPERTY INSURANCE

You can reduce your insurance cost and have quality protection. We also offer estate planning, malpractice and personal insurance coverage.

Call:

JOHN LUSK
Insurance Agents, Inc.
Two Northside 75
Atlanta, Ga. 30318
(404) 351-8434

BE THE DOCTOR YOU WANT TO BE.

Today, Navy Medicine gives you the opportunity to be the doctor you want to be. We offer a challenging practice with a minimum of administrative overhead. Plus excellent facilities and support personnel.

In addition, a Navy practice gives you time to spend with your family. Associate with other highly motivated physicians. Further your schooling. Even enjoy 30 days' paid vacation every year.

All this, plus a starting salary of $30,000 or more a year, depending on your experience.

For more information, contact:

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

Survivors include his widow, Josephine Elizabeth Miller Billings; a daughter, Ann Billings Mayne; four brothers; a sister; two grandchildren.

James Gordon Brantley

Wrightsville physician James Gordon Brantley died May 18 at the age of 90.

Dr. Brantley was born near Wrightsville and returned there after receiving his medical degree from Emory University School of Medicine (then Atlanta School of Medicine) and doing post-graduate work at Harvard Medical College and the Mayo Clinic. He practiced medicine in his native town for 65 years.

Survivors include a son, J. Marion Brantley; four sisters; three brothers; four grandchildren.

Leonard H. Campbell

Leonard H. Campbell, Bibb County Medical Examiner for the past 23 years, died March 2 at the age of 56.

Born in Arkansas, he was graduated from the University of Arkansas Medical School and later studied as a fellow in pathology at the Benning Institute of the University of Toronto.

He was a member of the American Academy of Forensic Sciences, the Southern Medical Association and the College of American Pathologists.

Survivors include his wife, Doris Townsend Campbell; a son, Leonard Mark Campbell; a daughter, Mrs. Michael Carlson; four sisters.

Thomas W. Goodwin

President of the Medical Association of Georgia for the year 1962-63, Thomas Wright Goodwin died March 24.

Born in Augusta, Dr. Goodwin graduated from the Medical College of Georgia in 1930 and then went on to serve as a fellow in surgery at the Mayo Clinic. In 1935, he returned to Augusta, where he had a private practice until 1969. He served as a Naval lieutenant in the South Pacific during World War II.

Until the time of his death, he was professor emeritus of clinical surgery at MCG. He also served as chairman of the Medical Education Board and as a member of the Georgia Board of Health.

He was a recipient of the coveted Distinguished Service Award presented by the Medical Association of Georgia.

Willis P. Jordan Sr.

The first and only medical director of the Garrard Alcoholism Clinic in Columbus, Willis P. Jordan Sr., died March 17 at the age of 80.

A native of Dawson, Dr. Jordan graduated from the Emory University School of Medicine. During World War I, he was a captain in the U.S. Army Medical Corps. Then he returned to Columbus and entered private practice.

After his retirement from full-time practice in 1966, he worked part-time with some 300 patients at the Clinic, the name of which was changed last year to the Garrard-Jordan Clinic, in his honor.

Dr. Jordan was past president of the Muscogee County Medical Society, past president of the Third District Medical Association, past president of the Georgia Urological Society, a former Chairman of the Board of Trustees of the Georgia Hospital Service Association and former director of the Southeastern Uro-

logical Association.

He was also a former chief of staff and was director of clinics and head of the intern-resident program at the Medical Center.

In 1967, he received a 50-year pin from MAG.

Survivors include his wife, Vivian Moates Jordan; three sons; seven grandchildren; four great-grandchildren.

Thomas Alexander Peterson

Orthopedic surgeon Thomas Alexander Peterson died March 31 at the age of 67.

Dr. Peterson attended Emory University and was graduated from the Medical College of Georgia. He went to Savannah in 1933, where he served his internship and residency and set up his practice.

During World War II, he served in the Army Medical Corps, spending much of that time as a surgeon at the Finney General Hospital in Thomasville. He was one of a group of Army surgeons who won distinction for advances in bone surgery during the war.

He served as president of the medical staff of Candler General (then Warren A. Candler Hospital) during the 1950s. He also had served as president of the Chatham-Savannah Health Council, president of the Seaboard Airline Railway surgeons and first vice-president of the Georgia Medical Society.

Survivors include his wife, Ruth Houton Peterson; a son, Thomas A. Peterson III; two daughters, Mrs. Paige Lee and Miss Jan Peterson; two brothers; a sister; three grandchildren.

Benghai Teh

Benghai (Jack) Teh, associate pathologist at Hamilton Memorial Hospital, Dalton, died March 7 at the age of 37. He was diagnosed as having a terminal illness in December 1975, but continued to work fulltime through September of last year and had worked part-time until a few weeks before his death.

Dr. Teh was honored last December by the Hospital Authority for continuing to devote his time and efforts to serving patients even while enduring health problems of his own.

Born in China, he received his medical degree from Taiwan University, served his residency at Taipei University and Greensburg, Pennsylvania, and his internship at Youngstown, Pennsylvania. He had been associate pathologist at Hamilton since June 1974.

Survivors include his wife, Shiwen Teh; daughter, Jenny Teh; son, Steve Teh; father; brother; three sisters.

John R. Walker

John R. Walker died March 31 at the age of 73. A native of Alpharetta, he was one of the oldest practicing physicians in the North Fulton area until shortly before his death.

Dr. Walker received his medical education from the University of Alabama Medical School and the University of Louisville, Kentucky, Medical School. He served as an intern at Grady Hospital, where he was later appointed chief resident of surgery in the 1930s. He was later the chief of staff at Crawford W. Long Memorial Hospital.

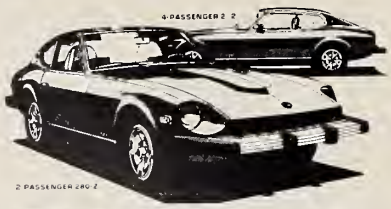
He was one of the founders of the Aidmore Children's Hospital of Atlanta and founder of the Catholic Clinic which later became Holy Family Hospital.

Survivors include him wife, Ruth Walker; daughter, Miss Virginia Kate Walker; a sister.

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD
2 MILES INSIDE I-285
Phone 455 1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND ...
We have the South's best service for the whole Datsun Line!

Office space ideal for Pediatrician or General Practitioner!

DeKalb Professional Building, 2754 N. Decatur Rd., conveniently located across from DeKalb General Hospital.

This office — 1,050 square feet is divided into a waiting room, business office, lab area, four examining rooms, private office/consultation room, two complete rest rooms, and dark room. Available for immediate occupancy.

For further information contact: Roy T. Summers
DeKalb Professional Building Suite 113
2754 N. Decatur Rd. Decatur, Georgia 30030
Telephone 292-3600



MAG SERVICES INCORPORATED

QUALITY AND INEXPENSIVE

PRINTING SERVICES FOR DOCTORS

PRESCRIPTION BLANKS

Standard Size 4¼ x 5½ in Pads of 100

500	1000	2000	4000
5.75	7.95	14.65	26.55

BUSINESS CARDS OR APPOINTMENT CARDS

	1000	2000	4000
White Stock One Side	6.95	12.65	22.95
For Color Stock, Add	1.00	2.00	4.00
For Two Sides	11.85	20.95	39.95

LETTERHEADS

20 LB. WHITE BOND				
SIZE	**500**	**1000**	**2000**	**4000**
7¼ x 10½ 8½ x 11	11.16	15.70	24.98	42.72
20 LB. RAG CONTENT (25%)				
7¼ x 10½ 8½ x 11	13.90	21.16	35.91	64.75

ENVELOPES

TO MATCH LETTERHEADS

24 LB. WHITE WOVE				
SIZE	**500**	**1000**	**2000**	**4000**
6¾	12.88	15.96	25.51	47.90
Monarch	13.70	17.59	28.76	54.40
#10	13.77	17.74	29.06	55.00
20 LB. RAG CONTENT				
Monarch	20.23	30.63	54.86	106.60
#10	20.86	33.97	57.43	111.75

WINDOW ENVELOPES

24 LB.

SIZE	500	1000	2000	4000
6¾	13.83	17.84	29.26	55.40
#10	14.85	19.89	33.36	63.60

Composition and type set charges are in addition to quoted prices.

UNIFORM INSURANCE CLAIM FORMS (Approved by AMA)

$18.50/1000 — Single Copies — Pads of 100

SEND ORDERS TO:

MAG SERVICES, INC.

(a service company of the Medical Association of Georgia)

968 PEACHTREE ST., N.E.
ATLANTA, GA. 30309
(404) 873-4136

BRIEF SUMMARY OF PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

ROERIG Pfizer

A division of Pfizer Pharmaceuticals
New York, New York 10017

When you're good people recognize you.

Highly effective
Single-dose convenience
Non-staining
Economical
Pleasant tasting

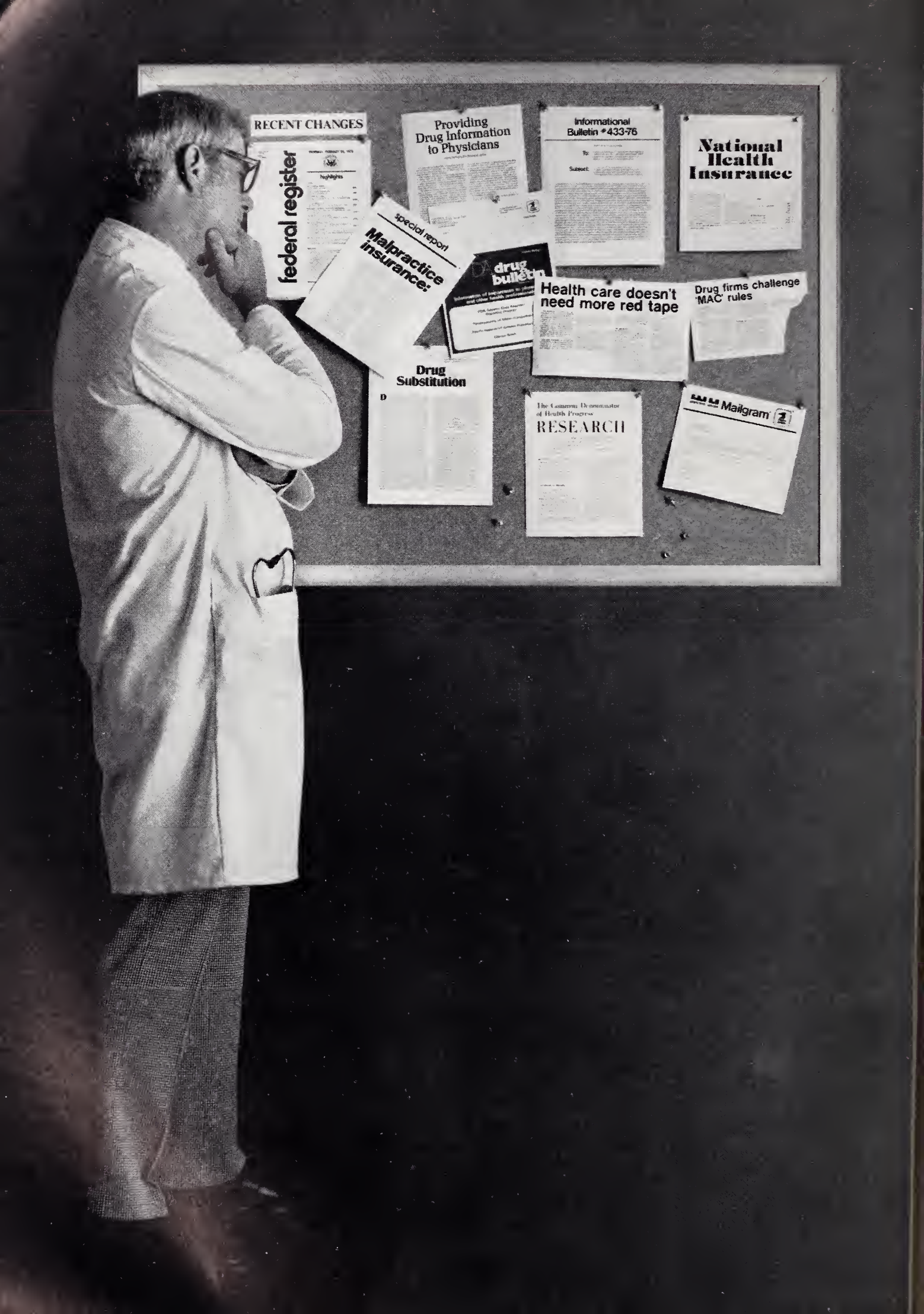
Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

©1977 LONE RANGER T.V., INC.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

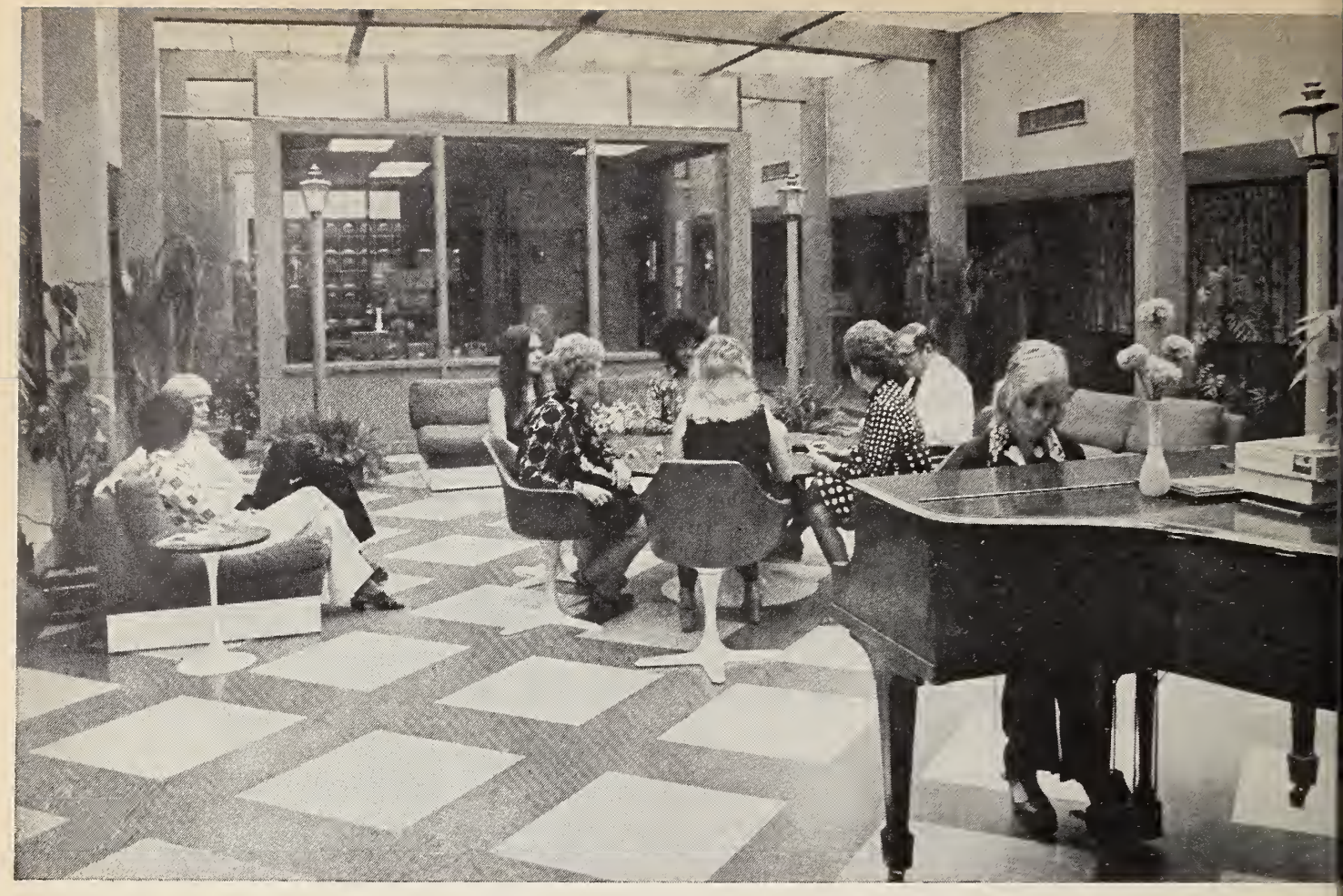
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



METROPOLITAN PSYCHIATRIC

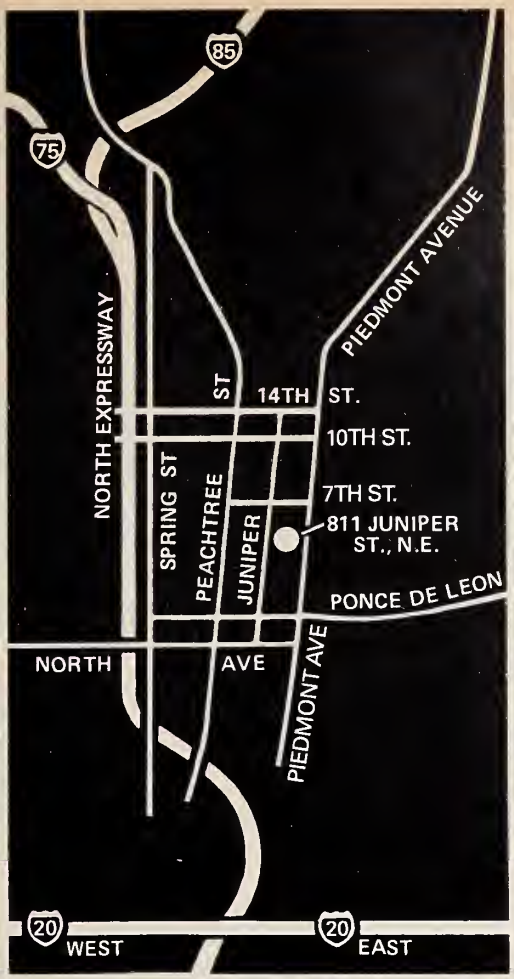
METROPOLITAN PSYCHIATRIC CENTER, centr located in midtown Atlanta, provides comprehensiv services for adult and adolescent patients in the area psychiatry and alcohol and drugs. Inpatient care, ou patient care and partial hospitalization programs are available at the Center.

In the Psychiatric Program, the attending psychiatrist determines from the comprehensive services availab the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

amily Counseling
sychological Testing
ocial Work Services
ducational Tutoring
ocational Rehabilitation Counseling
ull Radiology Services
ctivity Therapy Programs including Occupational herapy, Recreational Therapy and Art Therapy

he Metropolitan Alcohol and Drug Program, directed ward recovery, offers a structured, comprehensive proach to the treatment of the physical, psychological, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

oss Grumet, M.D.
edical Director

Custis L. Rosser, M.H.A.
Administrator

etropolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
1 Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

An Open Letter to Medical Professionals

Many physicians are seeking relief from the ever increasing pressures of medical practice within the private health care sector. The United States Air Force Medical Service is offering an alternative form of medical practice to all physicians who have not reached their 58th birthday. Frankly, we are proud of the quality health care the Air Force Medical Service provides and would briefly take this opportunity to present you a challenge to service.

The Air Force physician practices medicine in a collective endeavor with the entire gamut of medical specialties and the finest trained allied health care professionals. All United States Air Force Hospitals are accredited by the Joint Commission and are equipped with the finest medical instrumentation available. Health care is provided to every patient without regard to the patient's ability to pay. Opportunities for personnel development coupled with the professional challenges makes ours an ideal environment in which to serve. The Air Force physician has more time for family and personal development in comparison to his civilian counterpart. The liberal fringe benefits made available to the Air Force physician provide for secure, predictable and satisfying lifestyle; e. g., 30 day paid vacation annually, advancement, travel, medical education, professional pay and recreational opportunities.

Your time is very valuable and thus the brevity of this information offering. However, you owe it to yourself to consider this alternative medical practice. Positions are available in primary health care delivery and many medical specialties. Initial appointment can range in the grades Captain through Lt. Colonel with a starting salary range from $30,000-$40,000 (Bonus included) based on your education, civilian experience and prior U. S. military service. Assignments are arranged at specific Air Force Medical Facilities and are guaranteed prior to your commitment.

For further information contact:

Capt. Lohman D. Reiter
Suite 208, 3050 Presidential Dr.
Atlanta, Ga. 30340
Or Call Collect: (404) 451-3888

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

OFFICE TO SUBLET. Leaving practice. Will share office from July 1, 1977 to October 1, 1977, or sublet from October 1, 1977 to October 13, 1978. Office equipment also for sale. Decatur North Professional Building, downtown Decatur, Georgia. Call (404) 377-6459, 9-5, Monday through Friday.

ALABAMA: Emergency Physician: Full time, $70,000+ per year, fee for service, group health insurance, malpractice paid, funded continuing education, 305 bed regional medical center plus 350 bed community hospital and 100 bed community hospital with inhouse and outpatient responsibility. New ED facilities within 18 months with interns and resident teaching. Contact: Medical Director, P. O. Box 9639, Marina del Rey, CA 90291, Phone (213) 822-1312.

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital. 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Call 262-3580.

BOARD-CERTIFIED INTERNIST—VA Center, Dublin, Georgia. This is a full-time position which requires an internist with broad experience in the field of internal medicine preferably with emphasis in cardio-pulmonary diseases. Benefits—Life Insurance; Group Health; 30 annual and 15 days sick leave yearly; Educational Details and excellent retirement. No Malpractice Insurance necessary under Tort Claim Act when physician is serving in his or her capacity as VA employee. Dublin is a pleasant, tree-lined, smogless community within three-hour drive of uncrowded mountains and coastal areas. It is within two to three-hour drive of medical centers of Atlanta and Augusta. Ideal opportunity for both maintaining adequate income and preparation for Boards. Contact John B. Morton, M.D., Acting Chief of Staff, VA Center, Dublin, GA 31021, Telephone 912-272-1210, Ext. 202. Non-discrimination in employment.

FAMILY PRACTICE AVAILABLE. Large-volume practice and office building available due to death of mid-forty practitioner in January 1977. Practice fully equipped and located on main thoroughfare to Gatlinburg, Tennessee, in Sevierville, Tennessee. Extremely reasonably priced with excellent terms. Growing multi-specialty medical community, modern expanding hospital and nursing home facility in the foothills of the Great Smoky Mountains, only 40 minutes from Knoxville. Contact by calling collect (615) 453-3821 or (615) 693-0041.

EMERGENCY PHYSICIAN NEEDED. Must relocate to Griffin, Georgia (30 miles south of Atlanta). Work load: 20,000 patients annually. Flexible schedule with weekend work. Salary: guaranteed $22 per hour for minimum of 36 hours per week, with additional pay for weekends. Potential for profit sharing. Position available September 1, 1977; part-time available in August. Contact: Dr. Gail L. Lamb, M.D., 4800 Mumford Rd., Macon, Ga. 31204.

CANADIAN BORN, 33 year old, McGill University M.D., seven years in busy Family Practice, seeks to relocate from Toronto to Atlanta with congenial group. Extensive Obstetric, Emergency and Minor Surgery experience. Diplomate, National Board of Medical Examiners. Will consider all offers. Ed Powers, M.D., 14 Cobblestone Drive, Willowdale, Ontario, Canada M2J 2X7.

OVERSEAS EMPLOYMENT OPPORTUNITIES

Kwajalein, Marshall Islands

PHYSICIANS

Two full-time positions available now for family doctors experienced in general practice and/or pediatrics. One position also available for a general surgeon. The staff of physicians, together with a total hospital staff of about 50 persons, provide both inpatient and outpatient medical services for an island community of about 3500 persons, both civilian and military, including families with children, and single status men and women.

The 28-bed Kwajalein Hospital is modern and recently enlarged, and has a fully equipped outpatient clinic to handle the large flow of outpatients, plus excellent laboratory facilities.

Tropical climate on a lovely coral atoll. Fantastic scuba and snorkeling, tennis and golf.

Modern family housing available. Excellent, fully-accredited schools, kindergarten through high school.

U.S. Citizenship required. Comfortable living conditions. One year contracts. (Some shorter assignment of 3 to 6 months sometimes available on a single status basis). Vacation, bonus and other fringes. Potential U.S. Federal tax exemption. Reasonable cost of living.

Interested persons should RUSH curriculum vitae to: Clyde E. Albert, P.O. Box 12156, Oakland, Calif. 94604. An equal opportunity affirmative action employer.

GLOBAL ASSOCIATES

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.
Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Practice Productivity Inc.

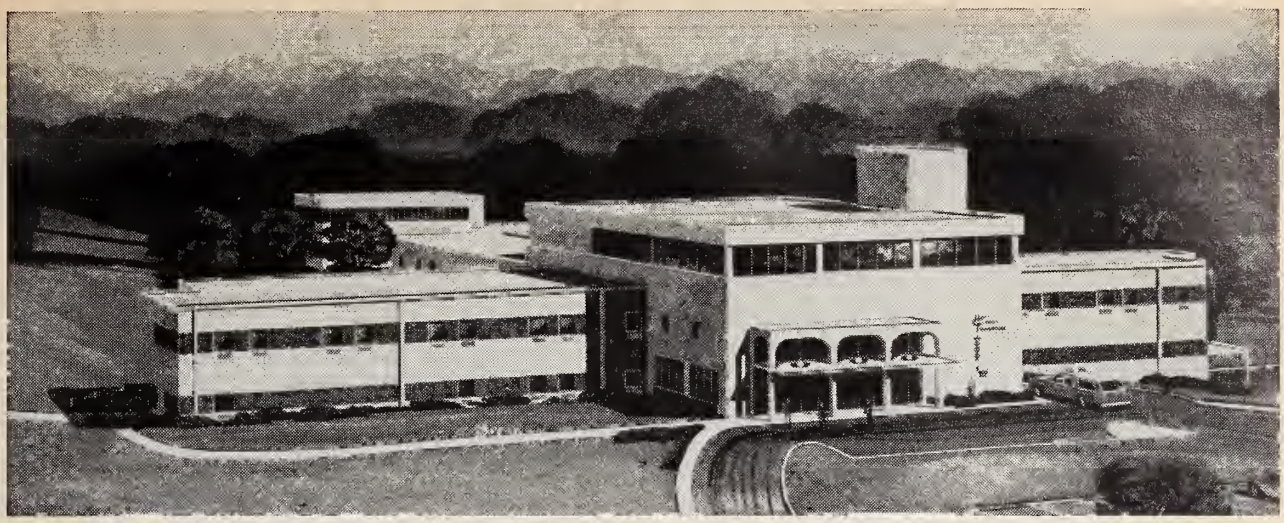
To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344



HILL CREST HOSPITAL

FOR INTENSIVE TREATMENT OF PSYCHIATRIC DISORDERS

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR:
Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

Index to Advertising

Vol. 66 June 1977 No. 6

Armour Pharmaceutical Company 493
Walter Ballard Optical Company 506
Beltone Electronics Corporation 471
Brawner Hospital, Inc. 350
Capital Automobile Company 487
Classified Advertising 505
DeKalb Professional Building 497
Dickey-Mangham Company 353
Eager and Simpson 402
Georgia Cancer Line 360
Georgia Society of CPAs 364
Global Associates 505
Hickman Datsun 497
Hill Crest Hospital 507
Kiawah Island 349
Eli Lilly and Company 354
J. C. Lindsey Realty 482
Lusk, John, Insurance Agent 496
MAG Services, Inc. 498
Metropolitan Psychiatric Center 502, 503
NCR Computer Systems 484
Non Invasive Cardiac Services, Inc. 353
O'Keefe Personnel Services 352
Peachtree and Parkwood Hospitals 486
Pennwalt Prescription Products 472, 473
Pharmaceutical Manufacturers Association 500, 501
Potter-Holden & Company 506
Practice Productivity, Inc. 506
Preferred Partnerships, Inc. 494
Roche Laboratories 348, 509, 510
Roster of the Medical Association of Georgia 388
Roerig 381, 498, 499
Sherwood's Commercial Broker 352
Smith, Kline & French 382
Squibb & Sons, Inc. 425, 426, 427, 428
United States Air Force 504
United States Navy 496
The Upjohn Company 474
Valley Psychiatric Hospital 402
Waronker, William, Silver Investment 487
Weight Watchers of Greater Atlanta 353
Willingway Hospital 352
1977 MAG Scientific Assembly 490

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Libri has been the object of ongoing pharmacologic and clinical investigatic

The published record on Librium is enormous. So large, in fact put it into a computer literature retrieval system to make it more accessi in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ℞
chlordiazepoxide HCl/Roche



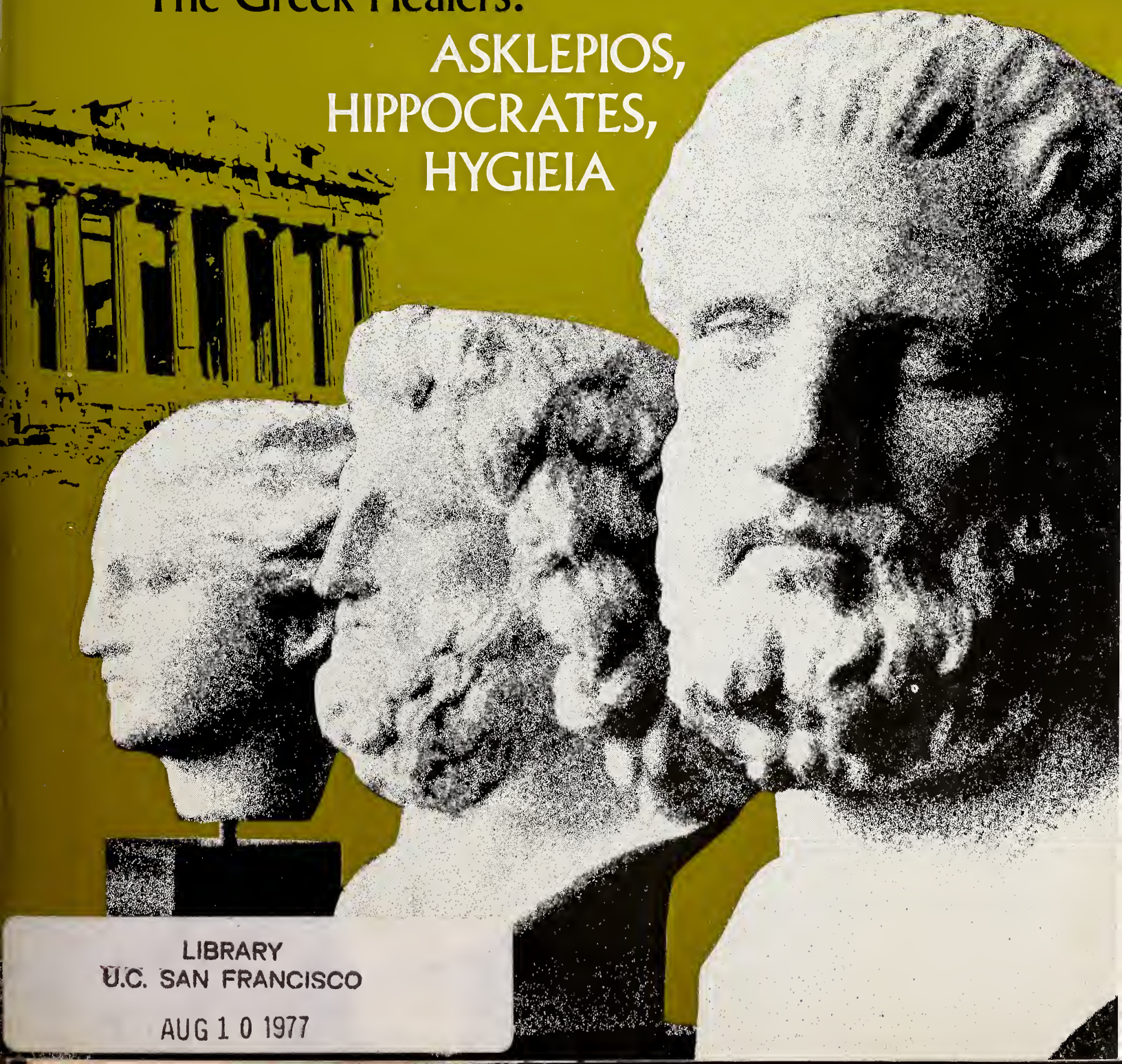
ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

JOURNAL
of the medical association of
georgia
JULY / 1977

The Greek Healers: ASKLEPIOS, HIPPOCRATES, HYGIEIA



LIBRARY
U.C. SAN FRANCISCO
AUG 1 0 1977

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

So near and yet so far away is not a contradiction.



Scott Hudgens Properties

Duluth Professional Park

IN GROWING GWINNETT COUNTY—A BEAUTIFUL OFFICE COMPLEX WITHIN A 1500-ACRE PLANNED UNIT DEVELOPMENT.

So near . . . Joan Glancy Memorial Hospital . . . Atlanta Athletic Club . . . major Northside corridors leading to metropolitan Atlanta . . . a growing community.

And yet so far away . . . from the hustle and bustle of the city. Each Williamsburg designed building has private entrances for staff and doctors . . . plenty of parking . . . plenty of peace and quiet.

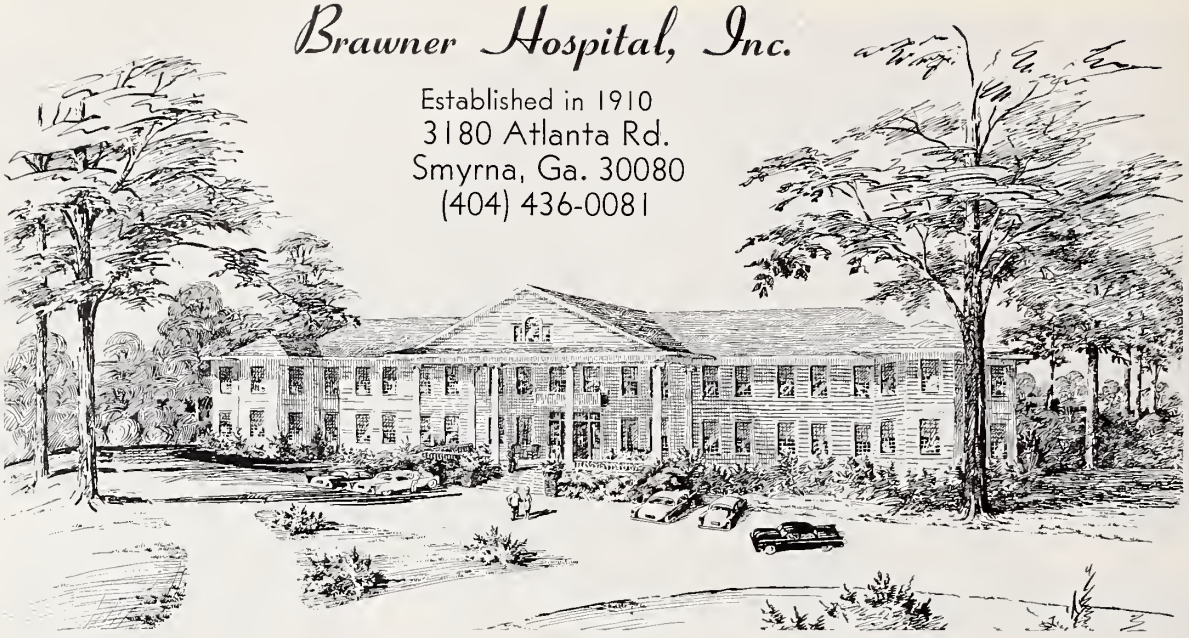
All new buildings . . . all are ground level. Competitive rates and custom-designed interiors make this a superlative opportunity.

Howell Station
ON THE RIVER

Contact
Dan Arnold
P.O. Box 988
Duluth, Ga. 30136
(404) 964-1351

Brawner Hospital, Inc.

Established in 1910
3180 Atlanta Rd.
Smyrna, Ga. 30080
(404) 436-0081



Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 7

EDITOR
Edgar Woody, Jr., M.D.

MANAGING EDITOR
Sharon T. Smith

BUSINESS MANAGER
L. B. Storey

CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta

PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS

Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.

Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

519 Volvulus of the Right Colon in the Post-Partum and Postoperative Patient
Jack Sorg, M.D.
William G. Whitaker Jr., M.D.
Lea Richmond, M.D.

534 The Pattern of Intussusception in Adults
Nicholas Harlafis, M.D.
John E. Skandalakis, M.D., Ph.D., F.A.C.S.
John T. Akin Jr., M.D., F.A.C.S.
Stephen W. Gray, Ph.D.
Constantine Droulias, M.D.

544 Antral and Pyloric Mucosal Diaphragm in Adults
Stephen W. Gray, Ph.D.
Henry C. Johnson Jr., M.D.
John E. Skandalakis, M.D., Ph.D., F.A.C.S.

558 Primary Adenocarcinoma in an Elongated Fallopian Tube
Jack Sorg, M.D.
Ernest M. Curtis, M.D.

SPECIAL ARTICLES

525 Televised Patient Education in a Community Hospital
Ann Rinaldi, R.N.
John Good, Ph.D.
Mark E. Silverman, M.D.

542 The Greek Healers: Asklepios, Hippocrates and Hygieia
Stephen W. Gray, Ph.D.

EDITORIALS

565 Piedmont, a Community Hospital, Alive and Well
Edgar Woody Jr., M.D.

FEATURES

567 President's Letter/1977 Scientific Assembly
Robert E. Perry Jr., M.D.

568 I've Told This Before/Called on the Carpet, But Not Electrocuted
J. Morgan Kellum, M.D.

571 Cancer Page/Tempest in the "Sugar" Bowl

572 Heart Page/The Evolution of Prosthetic Heart Valves
Douglas C. Morris, M.D.

577 Legal Page/Voluntary Binding Arbitration of Medical Malpractice Disputes in Georgia —Possibilities for New Legislation
Richard H. Vincent

THE ASSOCIATION

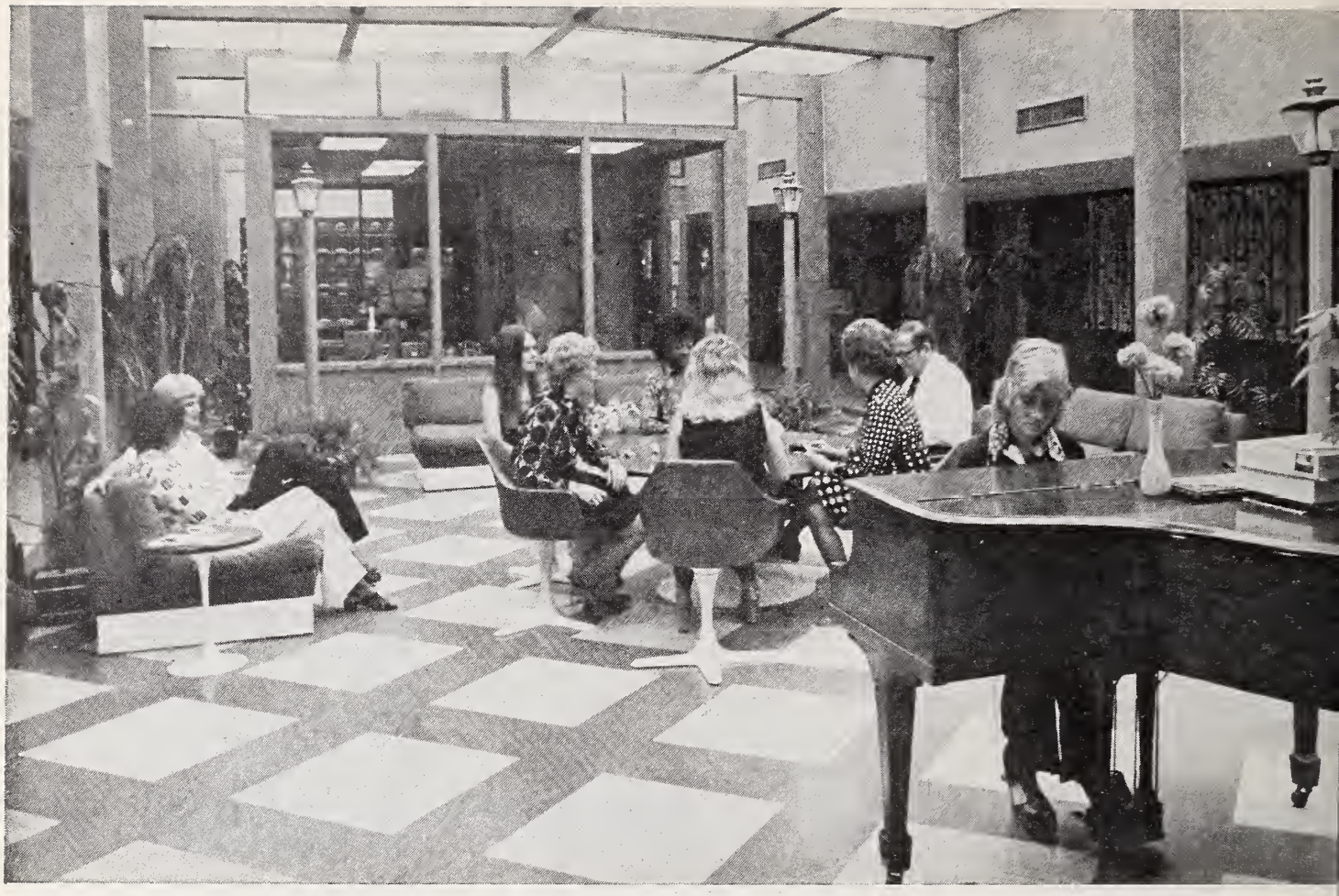
583 New Members
583 Personals
585 Deaths

NEWS

555 Medical Meetings Calendar
566 Letters to the Editor
579 Exhibits for Scientific Assembly
587 Speakers Bureau

THE COVER

Featured are Greek healers (left to right) Hygieia, Asklepios and Hippocrates. The photo is of three busts on display in the Woodruff Medical Administration Building, Emory University, and was taken by Bill Young. For more details on the effects these historical figures had on medicine, see Dr. Stephen W. Gray's article on page 542. Cover design by Bob Hamill, Atlanta.



METROPOLITAN PSYCHIATRIC

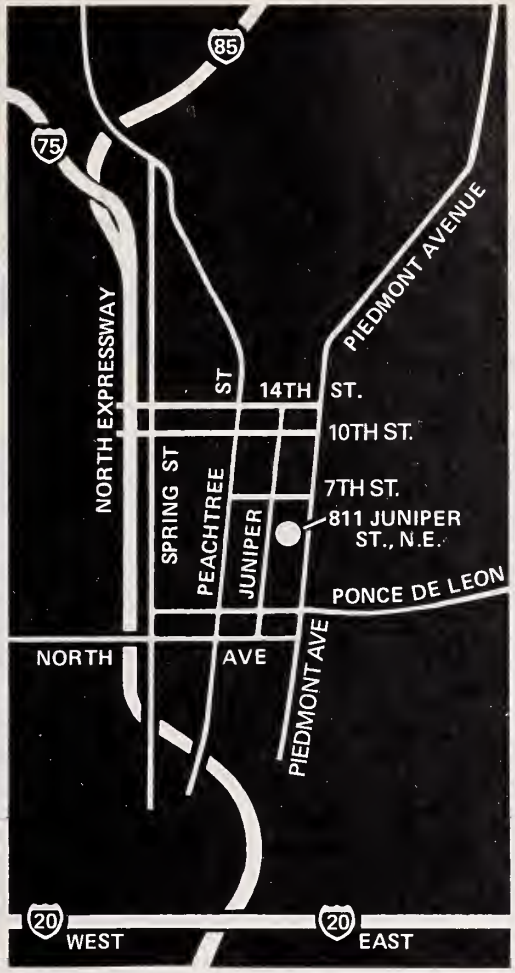
METROPOLITAN PSYCHIATRIC CENTER, centr
located in midtown Atlanta, provides comprehensiv
services for adult and adolescent patients in the area
psychiatry and alcohol and drugs. Inpatient care, ou
patient care and partial hospitalization programs are
available at the Center.

In the Psychiatric Program, the attending psychiatris
determines from the comprehensive services availa
the most appropriate modality(s) of treatment, but
always within the theme of individualized care.

The following services are available through the
psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

Family Counseling
Psychological Testing
Social Work Services
Educational Tutoring
Vocational Rehabilitation Counseling
Full Radiology Services
Activity Therapy Programs including Occupational Therapy, Recreational Therapy and Art Therapy

The Metropolitan Alcohol and Drug Program, directed toward recovery, offers a structured, comprehensive approach to the treatment of the physical, psychological, and socio-cultural aspects of the patient's needs. Thorough evaluations by both the medical doctor and the staff determine the course of each patient's treatment. Included in the Alcohol and Drug Program are the following services:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling

The Center provides 24 hour admission service.

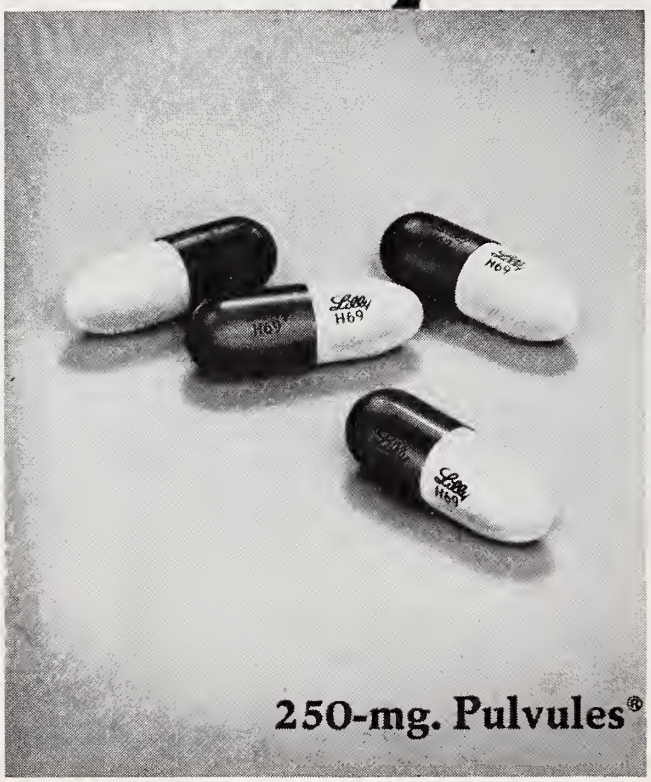
Additional information on the Psychiatric Program may be obtained by contacting Melinda Moakler, Admissions. For information on the Alcohol and Drug Program, contact Judith Gray, Program Director. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

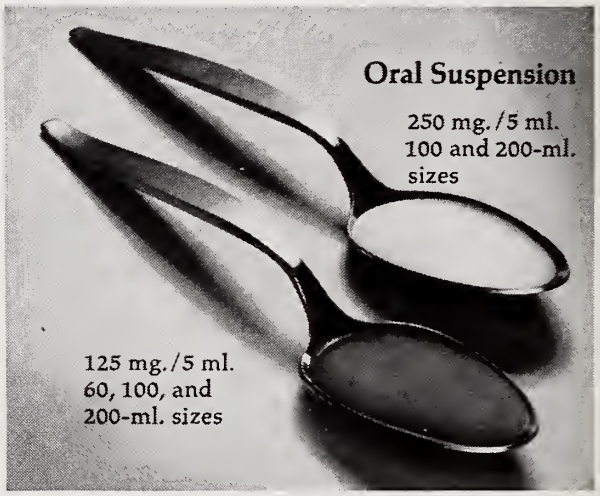
Joss Grumet, M.D.
Medical Director

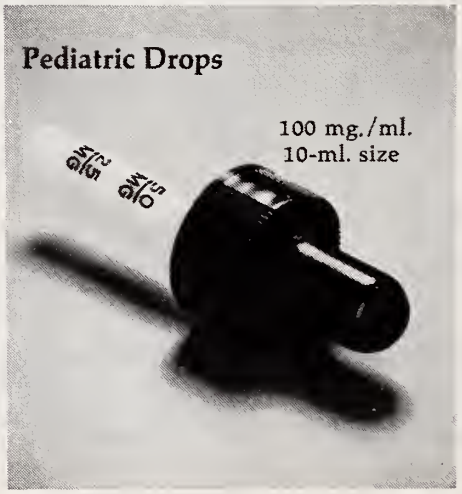
Custis L. Rosser, M.H.A.
Administrator

Metropolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
811 Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

easy to take







Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

JOURNAL
of the medical association of
georgia

Volvulus of the Right Colon in the Post-Partum and Postoperative Patient

JACK SORG, M.D., WILLIAM G. WHITAKER JR., M.D., *and*
LEA RICHMOND, M.D., *Atlanta**

VOLVULUS OF THE RIGHT COLON is an infrequent cause of intestinal obstruction as evidenced by the relatively few cases reported in the literature. In a collected series of 10,492 cases of intestinal obstruction, only 71 or .68% involved the proximal colon.[1] It is estimated that in 10-25% of the general population the cecum and right colon lacks peritoneal fixation and is mobile enough to allow kinking or twisting of that segment.[2]

The cecum descends into the right iliac fossa by the eighth month of intrauterine life and the right colon becomes fixed to peritoneum by the age of 4 months.[3] Incomplete rotation of the bowel or improper fixation must be present to allow volvulus of the cecum or right colon. Other inciting factors are high roughage diet, diarrhea, adhesions, postoperative ileus, abdominal trauma, obstruction of the left colon, or physical dislocation of the cecum as noted in pregnancy or the immediate post-partum period. When volvulus occurs in the immediate postoperative or post-partum period, it is frequently overlooked and misdiagnosed and often considerable time elapses before a definitive diagnosis is made.[4] The purpose of this paper is to call attention to the problems of cecal volvulus under this set of circumstances.

Case #1

A gravida four, para three female was admitted in early labor and underwent a normal delivery. During the early post-partum period, she complained of abdominal pain and revealed a slightly distended but soft abdomen with diminished peristalsis. On the fourth day, she vomited and her abdomen became more distended and quiet. Roentgenograms revealed free air in the abdominal cavity, and a diagnosis of rupture of the uterus was suspected. The abdominal problem was not fully appreciated until the fifth post-partum day when she presented a picture of peritonitis and gram negative sepsis and was taken to the Operating Room where cecal volvulus with perforation and peritonitis was encountered. An end-to-side ileotransverse colostomy was done and the bypassed cecum was left in place and decompressed with a cecostomy tube.

Postoperatively, she required ventilatory support for early respiratory problems. On the ninth postoperative day, bilateral subphrenic abscesses were drained. The remainder of her hospital course

* Dr. Sorg is Chief Resident in Surgery and Dr. Whitaker is Chairman of the Department of Surgery, Piedmont Hospital; Dr. Richmond is Chief of Surgery at Northside Hospital.

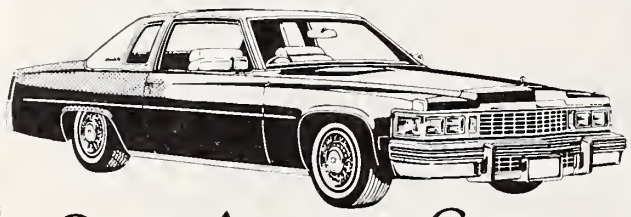
Capital Cadillac

SELLS AND LEASES

CADILLACS

FOR LESS THAN

ANY OTHER DEALER IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

HOLTER MONITOR FREE

HAVE YOUR OWN AVIONICS HOLTER TWO CHANNEL RECORDER IN YOUR OFFICE FREE THROUGH USE OF OUR SERVICE.

SCANNING CENTERS: Boca Raton Florida and Atlanta, Georgia

APPLICATIONS:

Diagnosis of Arrhythmia, Sick-Sinus,
Ischemia, Conduction Defects,
Pacemaker Function,
Correlate drug therapy and assay with 6 hour recording; Make 6 hour recordings part of annual health exams; record 4 to 6 patients per tape.
Holter Monitor your treadmill stress tests and record the following 23 hours.

FEATURES:

The latest state-of-the-art Recorder — FREE!
On-site training of your staff
All tape reports phoned
Mounted reports on your desk within 24 hours
No recording or scanning equipment obsolescense
Highly skilled, experienced Holter technologists scanning your tapes.

SEND TO: NON-INVASIVE CARDIAC SERVICES, INC.
P.O. Box 1167, 315 Golfview Drive
Boca Raton, Florida 33432

Name _____

Street _____

City/State _____ Zip _____

Phone _____



AVIONICS 445
AVIONCS RECORDER
1.6 lbs. with battery and recording tape

☐ Please send me more information on your scanning service.

☐ Please phone me with a description of the Free Recorder & Scanning Service.

☐ Have Holter Recorder and am interested in your scanning service.

was characterized by multiple organ failures, intra-abdominal bleeding, and repeated spontaneous perforations of the bowel requiring additional operative procedures and resulting finally in her death about four weeks following delivery.

Case #2

A sixty-five year old male had a diagnosis of carcinoma of the sigmoid colon. After appropriate bowel preparation, he underwent a radical left colectomy, at which time a rather mobile cecum and a Meckel's diverticulum were noted. During the next 14 days, he had several episodes of nausea, vomiting, and distention which were successfully treated with nasogastric suction. Abdominal roentgenograms during this time suggested intermittent ileus or early small bowel obstruction. On the fourteenth day, he became clinically obstructed and a meglumine diatrizoate and sodium diatrizoate (Gastrografin) enema confirmed the presence of colonic obstruction with a "bird's beak" at the midtrasverse colon and a large distended cecum. At operation a clockwise volvulus of the right colon was present and was held in this position by the adherence of the Meckel's diverticulum to the anastomotic suture line in the sigmoid colon (Fig. 1). After derotation a cecostomy and cecopexy were performed anchoring the colon in the right lower abdominal quadrant. The postoperative course was unremarkable except for urinary retention subsequently requiring a prostatectomy.

Case #3

A 24-year-old gravida two, para one, was delivered of a healthy male infant after an 8-hour uneventful labor. She was comfortable until 18 hours post-partum, as which time she experienced a gradual onset of intermittent pain in the right mid-abdomen, which quickly became excruciating and unrelieved by narcotics. Examination revealed moderate generalized distention and hypoactive peristalsis. Nausea was present, but there was no vomiting. Supine films of the abdomen demonstrated distention of the right colon without dilatation of the small bowel. Throughout the next few hours, abdominal pain increased in intensity and radiated to the back. The abdomen was soft and a large tender mass was found in the epigastrium. Twelve hours after the onset of pain, a barium enema revealed a block at the hepatic flexure, and a greatly distended cecum and ascending colon. A presumptive diagnosis of volvulus of the right colon was made.

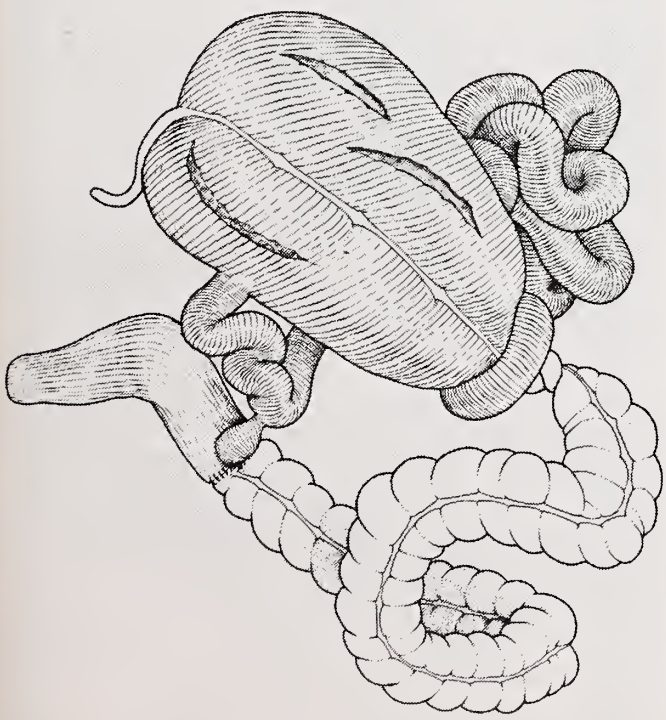




Fig. 1—Illustration of operative findings in Case #2. Note the Meckel's diverticulum adherent to the suture line of the left colectomy, holding the right colon in volvulus. Fig. 2—A preoperative barium enema showing a "bird's beak" deformity at the midtransverse colon.

Laparotomy was performed fifteen hours after the onset of pain and revealed a 360° volvulus involving the entire ascending colon, cecum and 12 inches of the terminal ileum. The clockwise volvulus was untwisted and the cecum fixed in the right lower quadrant by tube cecostomy. The postoperative course was uneventful and the patient was dismissed

One of the major problems of this condition is distinguishing it from the normal symptoms attributed to the early postoperative and post-partum period.

on the fifteenth day following surgery. The cecostomy, however, did not close spontaneously because of a sharp kink located at the hepatic flexure of the colon at the exact site of the previous torsion. Six months after dismissal from the hospital, a right colectomy was performed. Bowel continuity was restored by end-to-end ileo-transverse colostomy. Following this operation, the patient has remained well.

Case #4

A 35-year-old gravida two, para one, was delivered of a normal male infant after an uneventful labor of 8 hours duration. Her only complaint during the period of gestation was occasional mild abdominal distention and cramping pain. The past history is significant in that a diagnosis of appendicitis was made at the age of 16, at which time the abdomen was entered through a McBurney incision and the appendix was never found. During the morning of the first post-partum day, she complained of headache, lower abdominal cramps and mild distention. There was a desire to expel flatus which was aggravated by walking. Following an enema, flatus was expelled and the patient experienced some relief.

On the second post-partum day, abdominal distention was again noted, although the discomfort was minimal. During the third day abdominal distention became progressively worse, and there was recurrence of constant lower abdominal pain associated with nausea and vomiting. On the morning of the fourth post-partum day, a roentgenogram demonstrated a markedly dilated cecum lying in the left upper quadrant and a barium enema revealed a block in the hepatic flexure typical of torsion. The abdomen was distended and a tender spherical mass occupied the entire epigastrium. Exploratory laparotomy was carried out and the cecal volvulus was found. The cecum was tightly distended and there were several long serosal tears present on its surface. Aspiration was necessary before any attempt at untwisting could be carried out. The ascending colon, cecum, and terminal ileum were found to have undergone clockwise rotation of 360° at a point just distal to the hepatic flexure. Although there was ischemia of both large and small bowel, resection was unnecessary. Following reduction of the torsion, a cecostomy and cecopexy were performed.

The postoperative course was uneventful, cecostomy closed spontaneously, and the patient has remained well.

Case #5

A 21-year-old gravida three, para two, was admitted with a diagnosis of early term labor. Lower abdominal pain had been present for four hours and was increasing in severity. The pain was constant but intensified by cramps occurring at intervals of five to ten minutes, which were thought to be the pains of labor. Mild nausea was present but no vomiting. The abdomen was distended and peristalsis was present although hypoactive. Uterine contractions were of poor quality but appeared to be associated with an increase in abdominal pain. The fetal heart rate was 160 per minute.

Vaginal examination revealed a non-dilated cervix. At the end of four hours, there was no appreciable change noted in the patient's condition. Five hours after admission, pulse rate rose abruptly to 160, the blood pressure suddenly became unobtainable, and the fetal heart tones inaudible. The abdomen was palpated with some difficulty and there was a question of free fluid within the abdominal cavity. A presumptive diagnosis of ruptured uterus was considered and preparations made for immediate surgery, which was accomplished exactly 6 hours after admission. The abdominal cavity was entered through a low midline incision, a classical Cesarean section was performed, and a dead fetus was removed.

Following completion of Cesarean section, the abdominal viscera were examined and the lower jejunum, entire ileum, cecum, ascending and right transverse colon were found to have undergone a clockwise volvulus of 720° around the superior mesenteric artery. The bowel involved in the rotation was gangrenous and resection was necessary. Intestinal continuity was restored by end-to-end anastomosis between proximal ileum and the transverse colon. As anticipated, the postoperative course was complicated by diarrhea and electrolyte problems. Recovery was prolonged but the patient left the hospital in 17 days and is living an essentially normal life.

Discussion

There are classically three forms of cecal or right colon volvulus.[2] First is the fulminating type with early vascular compromise which progresses to perforation in a matter of hours. Second is the acute obstructive type (closed loop obstruction) which may develop over days or hours. Thirdly is the intermittent or recurring volvulus which may present symptoms over months or years before culminating in complete, unrelenting obstruction requiring emergency operative procedures. The signs and symptoms of volvulus are those of intestinal obstruction: colicky pain, nausea, vomiting, constipation, distention, and tenderness.

The problem lies in differentiating this condition from the usual symptoms attributed to the early postoperative or post-partum period. Ileus in the post-partum period persisting 24 hours or more on good medical management deserves radiographic evaluation which should clarify the condition and circumvent dangerous diagnostic delays. A most important point in management is a suspicion that the symptoms at hand may be those of obstruction requiring early diagnostic measures.

A roentgenologic diagnosis should be made preoperatively in the majority of cases, as the criteria are well established.[5, 6] On plain films of the abdomen (at and upright) one may use the following criteria:

1. Evidence suggesting small bowel obstruction with distended small bowel loops often just to the right of the cecum.
2. A greatly distended cecum with a single or rarely double fluid level.
3. A distended cecum in an ectopic position. If that position is in the left upper quadrant, then the stomach should be aspirated by a nasogastric tube and additional films obtained to differentiate the cecum from the stomach.
4. The concavity of the "coffee bean" deformity in the distended cecum directed toward the right lower quadrant.
5. Mucosal folds at the point of obstruction with spiral contour.

Ultimately, barium enema or surgical confirmation of the diagnosis is mandatory. Barium enema often demonstrates the "birds beak" deformity or a coning down to a point of the barium at the site of the twisted bowel (Fig. 2).

At operation, the overdistended cecum may show serosal tears, possibly gangrene, and usually a clockwise rotation of at least 90° about the fixed superior mesenteric artery. The first step in operative management is detorsion. This should be combined with at least some type of fixation of the cecum, usually with a cecostomy tube and cecopexy. Cecopexy itself may ultimately become inadequate unless it utilizes a flap of peritoneum for fixation.[7, 8] While a few surgeons advocate right colectomy as a routine procedure for all cases,[9] it is generally agreed that the presence of gangrene would certainly require resection of the segment. The results of surgical management in the early case without vascular compromise should be associated with a low acceptable mortality rate. It has been reported from zero to 27%.[10, 11] Delays in surgical management can result in disaster especially in the postoperative and post-partum patient.

Summary

1. Volvulus of the cecum or right colon is a rare type of obstruction and is caused by hypermobility of the cecum.
2. Pregnancy, delivery, and previous operations may be inciting factors in torsion of the right colon.
3. Volvulus occurring during the early post-partum or postoperative period is frequently unrecognized and may progress to gangrene and perforation before the patient is subjected to operative intervention.
4. Early supine and erect roentgenograms of the abdomen followed by barium enema should establish an early diagnosis.
5. Early operation is most important, utilizing resection for the compromised bowel and some type of decompression and cecopexy for obvious viable bowel.
6. Five cases of volvulus of the right colon occurring during post-partum and postoperative periods are presented emphasizing diagnostic delays often encountered under these circumstances.

REFERENCES

1. Villet, D. de G.: "Volvulus of the Proximal Colon," *Ann. Surg.* 150:1075, 1959.
2. Hendrick, J. W.: "Treatment of Volvulus of the Cecum and Right Colon," *Arch. Surg.* (Chicago) 88:364, 1964.
3. Rahbar, A., Easley, G. W. and Mendoza, C. B.: "Volvulus of the Cecum," *Am. Surg.* 39:325, 1973.
4. Whitaker, W. G. Jr. and Howell, T. S. Jr.: "Volvulus of the Cecum Complicating Pregnancy: A Report of Three Cases," *Am. Surg.* 24:753, 1958.
5. Figiel, L. S. and Figiel, S. J.: "Volvulus of the Cecum and Ascending Colon," *Radiology* 61:496, 1953.
6. Krippaehne, W. W., Vetto, R. M. and Jenkins, C. C.: "Volvulus of the Ascending Colon: A Report of 22 Cases," *Am. J. Surg.* 114:323, 1967.
7. Nelson, T. G. and Bowers, W. F.: "Volvulus of Cecum and Sigmoid," *A.M.A. Arch. Surg.* 72:469, 1956.
8. Bystrom, J., Backman, L., Dencker, H. and Meden-Brith, G.: "Volvulus of the Caecum," *Acta Chir. Scand.* 138:624, 1972.
9. Andersson, A., Bergdahl, L. and Van Der Liden, W.: "Volvulus of the Cecum," *Ann. Surg.* 181:876, 1975.
10. Siegler, A. M. and Rogatnick, S. H.: "Cesarean Section Complicated Post-Partum by Volvulus," *Am. J. Obstet. Gynec.* 80:551, 1960.
11. Wolf, R. Y. and Wilson, H.: "Emergency Operation for Volvulus of the Cecum: Review of 22 Cases," *Am. Surg.* 32:96, 1966.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

Practice where the big premium is on medical care.

Not on high overhead. Or paperwork. Or any of the other hassles that keep chipping away at your clinical time.

If you want more out of your medical career, consider what the Navy can offer. A ready-made practice where patients' medical care is independent of the fluctuations of the economy. An engaging life-style. Adventure. Travel. And as much as $30,000 to $40,000 a year to start.

This year the Navy needs General Practitioners for the Flight Surgeon program, for Undersea Medicine, and as General Medical Officers. We also need specialists in Anesthesiology, Family Practice, Psychiatry, Internal Medicine, Neurology, Radiology, Pathology, and Pediatrics. If your interests lie in any of these clinical areas, and you'd like to get back to pure medicine, the Navy is for you. Get all the facts from your local Navy medical recruiter.

Fewer than 200 physicians are needed, so don't delay.

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

WARNING
THIS MATERIAL MAY BE PROTECTED BY COPYRIGHT LAW (TITLE 17 U.S. CODE)

Televised Patient Education in a Community Hospital

ANN RINALDI, R.N., JOHN GOOD, Ph.D., *and* MARK E. SILVERMAN, M.D., *Atlanta**

Piedmont Hospital has developed an effective program of patient and staff education through the use of its own television studio.

HOSPITALIZED PATIENTS, like modern children, spend much of their spare time watching television. Although as yet unproven, it seems reasonable to suppose that an infusion of soap operas, game shows, and sitcoms does not provide a long-term therapeutic benefit. On the other hand, television also offers the possibility of injecting a bolus of patient education that will reach a captive audience with information that may contribute to improved health. With this in mind, the patient education department of Piedmont Hospital developed a concept of a closed circuit television network to provide educational programs that might lead to improved health and self care, to facilitate education and communication among physicians, administration and employees, and to provide entertainment and information for patients, to make their stay as pleasurable as possible.

This article describes the organizational and developmental aspects of this program for use as possible guidelines for hospitals interested in a similar pursuit.

Organization and Staffing

The television studio is located on the basement floor of the hospital as part of the Department of Training and Education. This department is a division of the hospital and is supervised by an assistant administrator with a background in educational psychology. The division also includes in-service education, patient education, the medical library, and general education for non-nursing personnel. A full-time technician with background in video production is in charge of the equipment and assists in program development. There are full-time coordinators of patient education and general education. A patient education committee, consisting of the above people, a physician, and several staff nurses meet monthly to plan new educational programs and to critique on-going projects.

Description of the Production Facilities

The television studio is 16 by 32 feet, with a 12-foot ceiling. Adjacent to the studio is a control room measuring ten by 12 feet. The studio area is carpeted for quietness, and draped to improve acoustical qualities. All of the drapes are on traverse rods, and the walls behind them are painted in various colors to represent different areas of the hospital. For production purposes the studio is divided into three areas. Lighting is provided by eight 400-watt fixtures, and the fixtures are mounted on a grid which criss-crosses the studio. Using the grid, the fixtures

* The Department of Medicine, Emory University School of Medicine and the Department of Training and Education and the Department of Medicine, Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta, Ga. 30309.

can easily be moved to any position desired, saving the expense of different lights for each production area.

Many considerations were incorporated into the planning of the studio. For example, the air condition ducts enter the studio from the sides rather than the ceiling as they do in other areas of the hospital. This is to avoid blowing cold air over the hot production lights. Baffles were built into the ducts to reduce noise, and a special thermostat is used to increase the amount of cool air when the lights are turned on. The main door is wide enough to move a hospital bed through, and all doors are soundproof. The electrical circuits for both the studio and the control room provide twenty-, thirty- and forty-amp capacities, and all lights in the studio are operated from the control room.

The production equipment includes two color Panasonic cameras with zoom lenses. The cameras are linked to a production console, which provides switching, special effects and audio mixing capabilities. For recording and editing, two Panasonic ½" reel-to-reel video tape recorders are used. A Bhul multiplex with a 16 mm projector and two 35 mm slide projectors are used to provide video copies of movies and slides. A video "jukebox," capable of automatically changing ¾" video cassettes, is programmed to begin broadcasting at 7:00 A.M. After automatically playing 12 hours of programs, the video jukebox rewinds each tape, returns to the "Start" position, and waits until 7:00 A.M. the following morning to begin a new broadcast. The signal from the video jukebox is transmitted from the television studio, located in the basement of the hospital, to the master antenna system on the top floor via CO-AX Cable. The master antenna delivers the signal through cables that travel throughout the hospital directly to 19-inch color television sets suspended near the ceiling in each patient room. The patients can select any commercial channel or Channel 3, the Patient Information and Education TV System (PIES). Stickers are placed on the television sets to remind them to tune in to Channel 3.

This powerful medium is playing a significant role in the educational programs at Piedmont Hospital.

A Magnavox portable color camera is used for recording at locations away from the studio. The tape is then brought back to the control room for editing, audio mixing, and conversion to video cassette.

Program Development

Programming began in April 1976. The original program content consisted primarily of educational films obtained mainly through non-profit service organizations such as the American Heart Association, the American Cancer Society, and the Arthritis Foundation. Examples of these include "For a Wonderful Life" and "Let's Call It Quits" from the American Cancer Society, and "What Goes Up" and "Eat to Your Heart's Content" from the American Heart Association.

Private companies producing films and video tapes designed for patient education are numerous. Three companies which produce quality programs are:

American Learning Systems
1106 Jeanette Avenue
Columbus, Georgia 31906
(404) 327-2619

Medi-Cine Sales Corporation
10 North Tacoma Avenue
Indianapolis, Indiana 46201
(317) 637-1583

Trainex—Patient Video Corporation
Suite 150—10 Perimeter Place, NW
Atlanta, Georgia 30339
(404) 433-0755

The price of these programs range from $150.00 to $300.00 per program. Many companies produce programs for lease on a yearly basis.

All members of the Piedmont Hospital Education Department participate in developing and producing video programs. The programs may provide information about the hospital and its personnel or about some aspect of disease and health care.

Several patient education tapes have now been produced, including one on hypertension using the format of the television panel show, "What's My Line?." In this program a blindfolded panel attempt to guess the identity of the "Silent Killer" who turns out to be *hypertension.* The script was written by a staff physician and nurse, and utilizes members of the hospital staff as actors. Scripts are usually written by members of the Training Department staff and approved for content by one or more physicians. Actors are generally chosen from the hospital staff.

The informational programs include subjects such as "Welcome to Piedmont," a complete tour of the hospital and its facilities, including areas that many

patients never see. This tape explains what the patient can anticipate during the hospital stay, introduces some of the hospital staff, and instructs the patient where to obtain information. Information for visitors, such as cafeteria and gift shop hours and the location of various services, is also given. Another program, "Mr. Williams Goes to Surgery," is shown each evening, providing a basic orientation for surgical patients. The patient is given information about the preoperative, operative and postoperative period.

Patients can tune to Channel 3 and get a guided tour of the hospital, orientation for surgery, health tips and many other educational benefits.

"Person to Person" uses a talk show format to inform patients about the roles and responsibilities of the Piedmont staff members who provide their care. For example, a head nurse, a staff nurse, and a nursing assistant discuss each of their separate roles. "Hospital Update," produced weekly and aired four times a week, gives current news about departments, people, and activities around and about Piedmont Hospital. Information programs are in production which will highlight various departments in the hospital, such as X-Ray and Physical Therapy. These programs explain the functions of the departments and their contributions to patient care.

The TV studio is currently producing two to three hours of material monthly. Presently 35 programs are broadcast on a rotating basis throughout the 12-hour broadcast day. To maintain interest, educational programs are alternated with travelogues and human interest films. By the end of 1977, more than 65 programs should be available. A program guide listing the time of each program and a brief description of the program is given to each patient on admission to the hospital (see sample program guide). A typical day's programming includes a program explaining the danger signals of cancer, information about good nutrition, a how-to first aid course, and information about the heart and heart attacks.

Programs are being produced on diet and hypertension, exercises for the bed patient, deep breathing and coughing for the preoperative patient, cancer and cancer therapy. Plans have been made to produce comprehensive coverage of certain topics such as diabetes. This program would include a discussion of the physiology of diabetes, a panel discussion by diabetics, and a program on the diabetic diet.

One survey has been taken to evaluate patient response to televised education. The results show that about 50% view the programs and the interest in the material is excellent.

Other Uses of TV Production Facilities

A television production facility can also produc programs for the hospital staff and employees. Thi can be helpful in solving one of the greatest prob lems of hospital education, that is, providing suffi cient instruction for all the shifts, including full- an part-time employees. By taping educational pro grams and making them available in the Medical Li brary on a check-out basis, the nursing staff and oth er employees involved in patient care are able to re main current with developments in their fields. Th staff can also view the patient educational program so they can be familiar with the material and answe questions from the patients.

Videotapes are also used in the Patient Educatio Center. The Patient Education Center offers a varie ty of audiovisual and printed materials for inpa tients, outpatients, and their families. The videotape are taken from the programs shown on the closed circuit system as well as tapes of our monthly Com munity Conferences. Each patient is informed abou the Center on admission, and may visit the Cente at any time during the day. Patients may also be re ferred to the Center by physicians and by the nursin staff.

Summary

Television can be an effective medium of provid ing patient education if it is used as part of a com prehensive program emphasizing individual instruc tion and problem solving as well. This approach re quires close cooperation and frequent interaction be tween the patient education coordinator and the staf nurse who helps to identify health problems, stimu late the patients to watch the programs, and assis the physician in answering patient questions.

Television can also play an integral role in in service education because of its 24-hour availabilit and the advantage that the material can be reviewe as often as necessary. We are also considering th feasibility of transmitting the programs directly t the waiting areas of the physicians' offices in the ad joining professional building. Although there is significant initial investment of approximatel $50,000 for production equipment, we feel that tele vision is playing a significant role in the educationa programs at Piedmont Hospital.

Acknowledgement

We are very appreciative to Dr. J. Willis Hurs who stimulated the initial concept of a patient edu cation center and has given many suggestions tha have furthered its development.

SAMPLE PROGRAM GUIDE

7-7:30 AM SEASONS A scenic journey through the seasons of the year via colorful still pictures. Accompanied by favorite musical selections.

7:30-8 THE GRIZZLY BEAR A candid look at this unpredictable creature of the wild.

8-8:15 FOR A WONDERFUL LIFE Examines the reasons for periodic Pap smear and examination for uterine cancer.

8:15-8:30 BUSCH GARDENS WEST A delightful filmic visit to a spectacular attraction in Los Angeles.

8:30-9 HIGHLAND FLING Travel the ski slopes with professionals out for fun and games.

9-9:15 INSIDE MAGOO Humorous animated approach to explaining cancer's seven danger signals to men.

9:30-10 AHEAD OF THE CROWN Viewers meet ten top athletes who have a drive to succeed as a result of setting goals.

10-10:15 MAGIC OF HOBBY CERAMICS An opportunity to pick up tips as you window shop into this exciting new hobby.

10:15-10:30 EATING ON THE RUN Good nutritional balance is still possible, even at today's hectic pace.

10:30-11 MAN, THE INCREDIBLE MACHINE National Geographic spectacular journey through the most sophisticated machine. Extraordinary photographic techniques take us inside many of its parts heretofore never viewed.

11-11:30 HOSPITAL UPDATE News of departments, people and activities around and about Piedmont Hospital. Followed by **SEASONS,** a pictorial journey of the seasons of the year.

11:30-12 FIRST AID, SECOND NATURE Viewers are shown re-enactments of several common household accidents and quizzed on the proper first aid techniques for the injured victims.

12:00-12:30 BETTER ODDS FOR A LONGER LIFE Animated approach to how best to take care of the heart.

12:30-1 AMERICAN FARMER A probe into the life and work of the changing farmer, and a look into his future.

1-1:15 ONE IN SIXTEEN MILLION A provocative program about arthritis: causes, effects and treatment.

1:15-1:30 AFRICA NEXT DOOR Share the excitement, mystery and drama of Africa at Busch Gardens in Tampa.

1:30-2 LET'S CALL IT QUITS Humorous story of how a group of friends decides to quit smoking and how difficult (but possible) it is for one member of the group.

2-2:30 THIS IS HAWAII Join host Don Ho for a musical tour through the beautiful Islands.

2:30-3 I AM JOE'S HEART This film features Joe, an average American, and helps us understand the heart, risk factors and what we can do to better "heart health."

3-3:30 SEASONS A scenic journey through the seasons of the year via colorful still pictures. Accompanied by favorite musical selections.

3:30-3:45 GAMEPLAN: LIFE! Entertainer Danny Kaye relates from personal experience how a person can lead a full and active life after a heart attack.

3:45-4 PERSON TO PERSON A glimpse of those Piedmont staff members who'll be coming into patients' rooms . . . their roles in patient care.

4-4:30 BAVARIA An exciting travelogue into this picturesque European area.

4:30-5 MOONFLIGHTS & MEDICINE Explains how modern medicine has benefitted from America's space program.

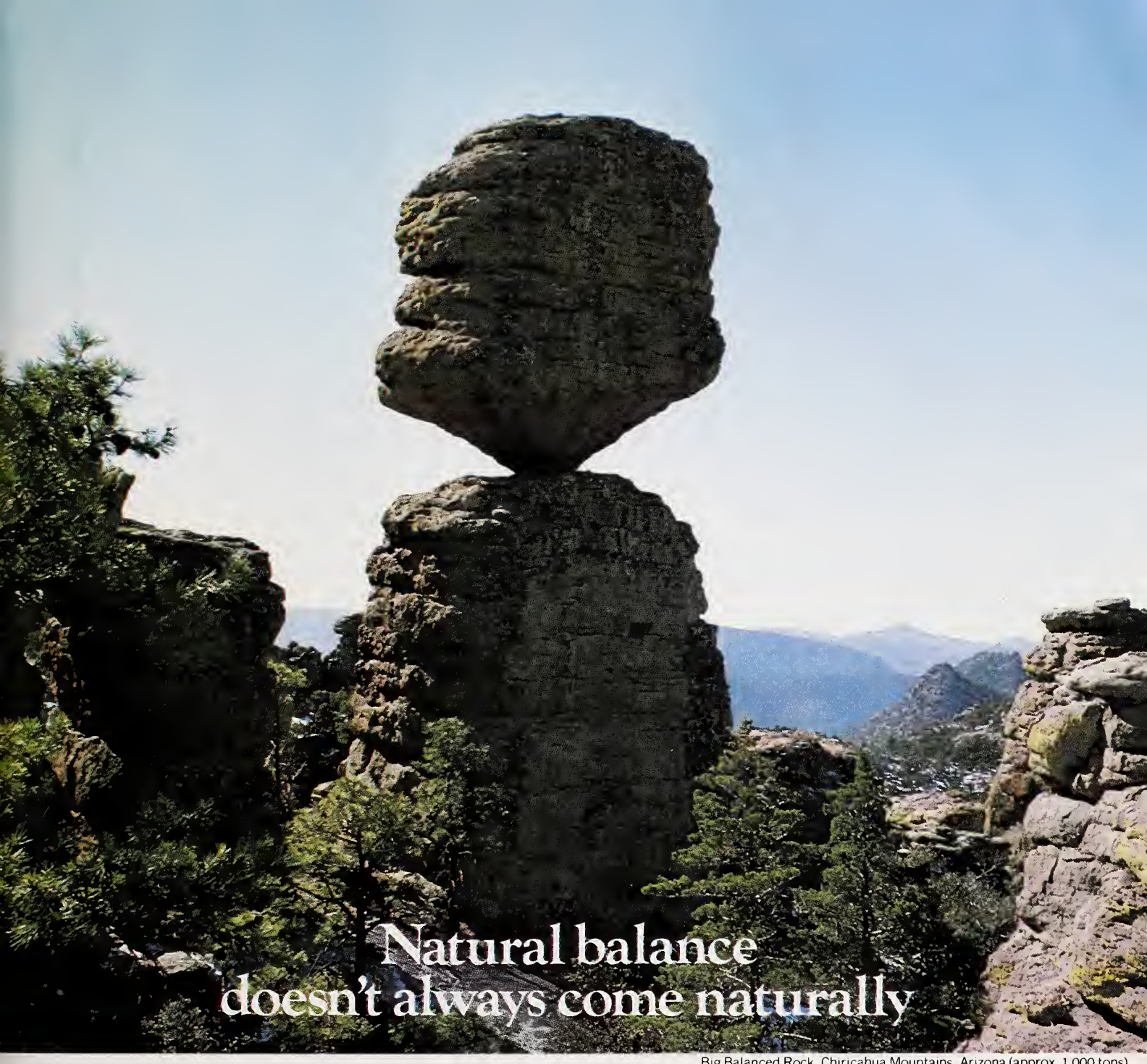
5-5:30 AZALEA TRAIL, U.S.A. A color extravaganza featuring this prized flower.

5:30-6 WHAT'S MY PROBLEM Produced at Piedmont, this satire analyzes "The Silent Killer" . . . high blood pressure.

6-6:30 MAGIC OF DISNEYWORLD A trip through the exciting new fantasy land in Orlando.

6:30-6:45 WELCOME TO PIEDMONT A patient's introduction to the hospital's various departments and services.

6:45-7 MR. WILLIAMS GOES TO SURGERY An orientation covering the basics in preoperative, surgical and postoperative procedures. Taped at Piedmont especially for patients awaiting surgery.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25

(meclizine HCl) 25 mg. Tablets
for vertigo*

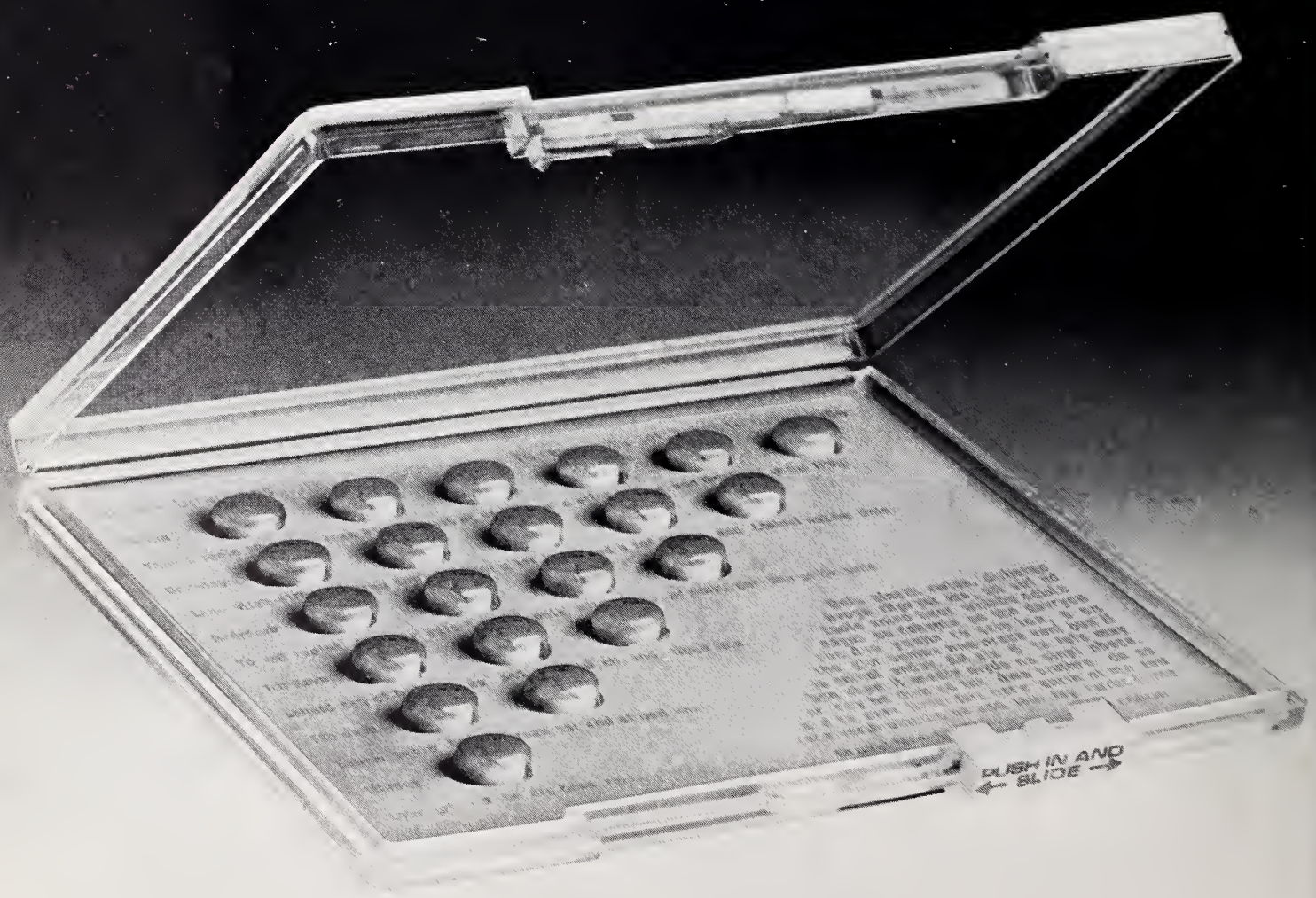
Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



*Trademark

J 5741-4

©1977 The Upjohn Company

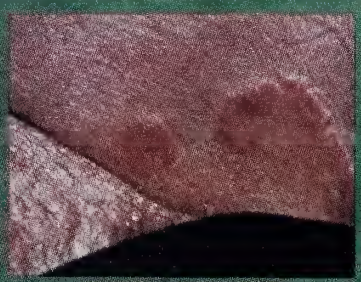
When Griseofulvin is indicated...



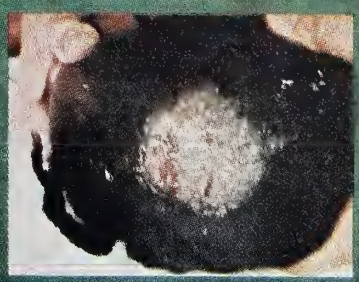
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



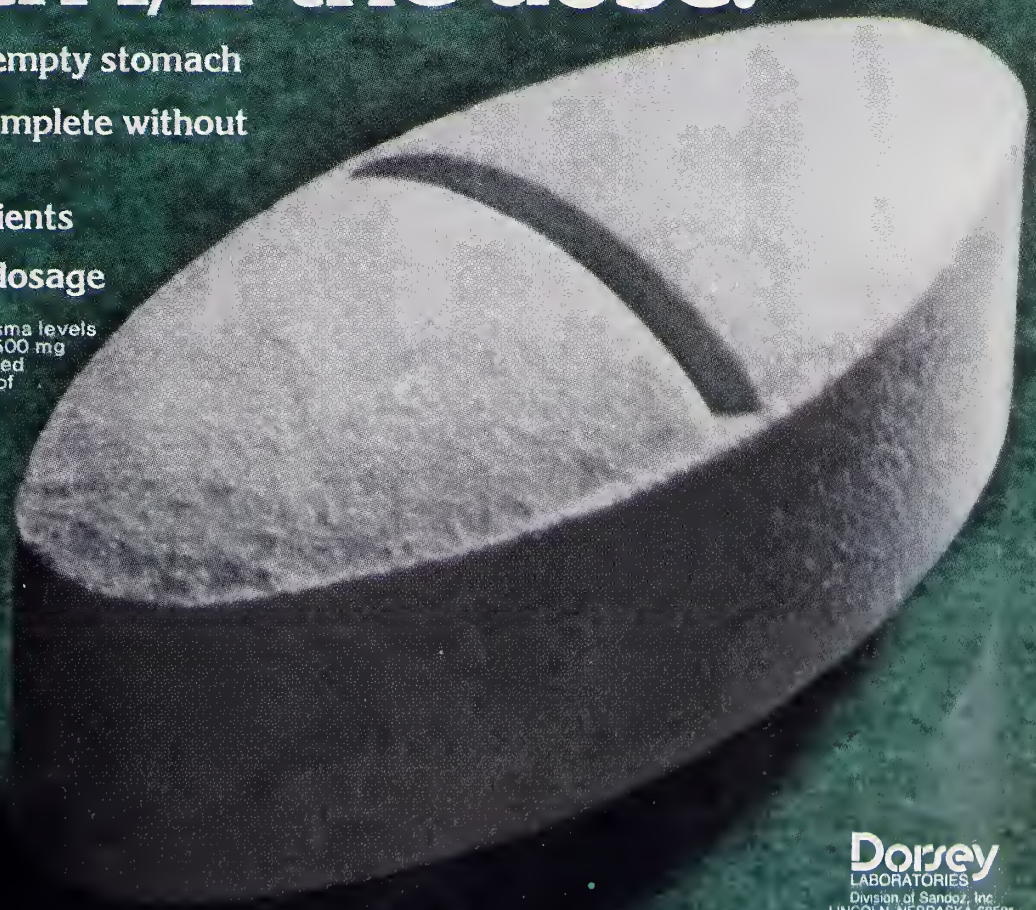
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

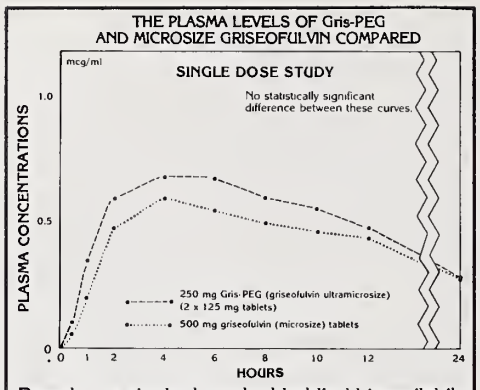
†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



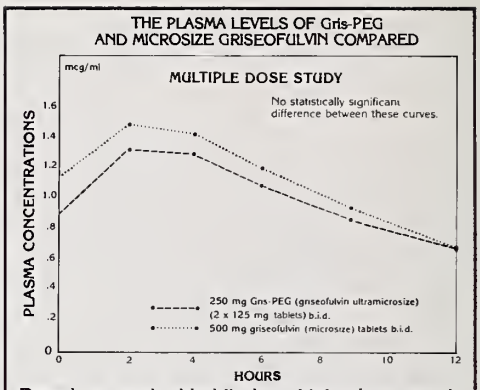
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

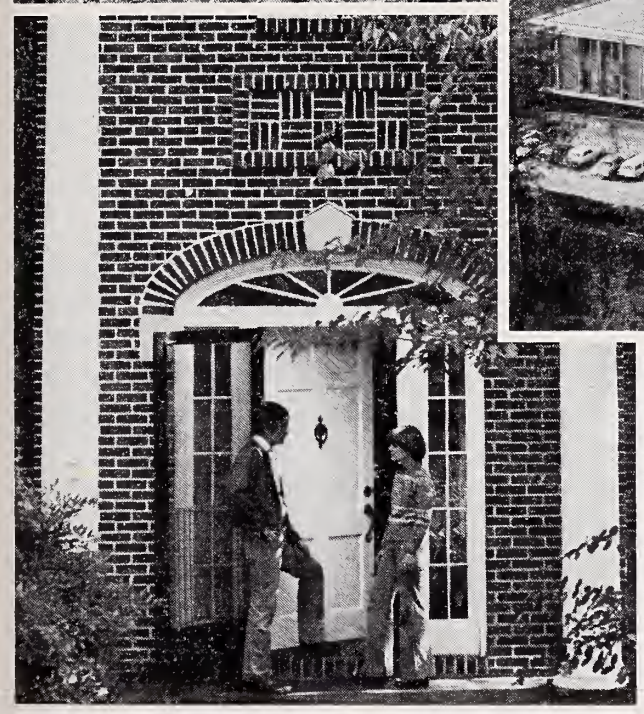
Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

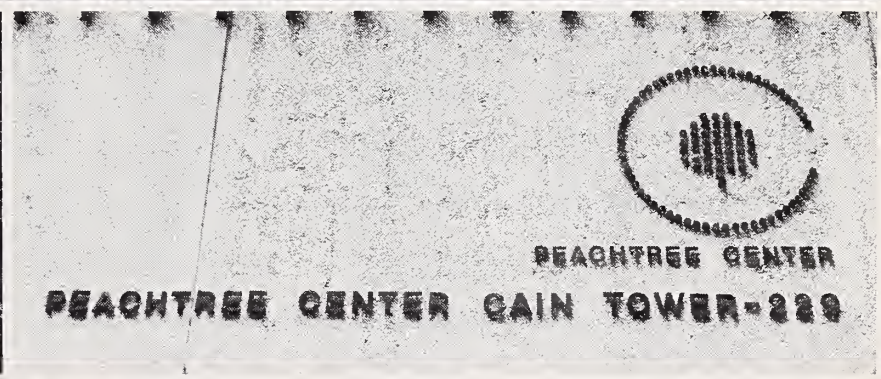
Dorsey LABORATORIES











PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Several changes have occurred over the years in the pattern of intussusception, including the fact that only five percent are found in adults.

The Pattern of Intussusception in Adults

NICHOLAS HARLAFTIS, M.D., JOHN E. SKANDALAKIS, M.D., Ph.D., F.A.C.S., CONSTANTINE DROULIAS, M.D., STEPHEN W. GRAY, Ph.D., *and* JOHN T. AKIN JR., M.D., F.A.C.S., *Atlanta*

SIXTY-SIX YEARS AGO, Eliot and Corscaden[5] collected 231 cases of intussusception from the literature. Of these, 213 were in patients over 10 years of age. Childhood intussusception was hardly recognized, elderly patients were few, malignant tumors were a minor cause of the disease, and the mortality was 34 percent.

The present series of cases illustrate some of the changes that have occurred in the pattern of intussusception. We now know that 95 percent of intussusceptions affect infants and children and only 5 percent are found in adults. The disease is still uncommon in adults; it has been estimated that there have been 1,186 cases reported from 1900 to 1971.[9] The most recent reviews are those of Roper,[7] in 1956 and Weilbaecher and his colleagues[9] in 1971.

MATERIAL

During an eight-year period from January 1967 through December 1974, 33 patients over the age of 14 years with intussusception were seen at six Atlanta hospitals. All cases were confirmed by surgery or autopsy. They are summarized in Table 1.

DISCUSSION

Sex and Age

In some series there is a preponderance of males;[5] in others, there are more females.[8, 9] It is probable that no sex difference exists except in patients with intussusception caused by Meckel's diverticulum. Such intussusceptions are more common in children than in adults.

The most marked shift is in the number of older patients. In the 1911 series, only 1.9 percent were 70 years old or older; among our patients, 21.2 percent were in this age group.

Etiology

Intussusceptions may be divided into those having a known intrinsic cause and those to which no probable cause can be assigned. These latter are called idiopathic. They comprise about 90 percent of intussusceptions found in infants, but are much less common in adults.

Idiopathic intussusceptions make up one-third of our cases. This incidence is comparable to that found by Eliot and Corscaden[5] and by Deterling and his associates,[3] but greater than that found in some other series.[2, 7, 9]

Tumors, benign and malignant, are a major cause of intussusception (Table 2). In older series, benign tumors were more frequently involved than were malignant tumors.[4, 5] This relation has become reversed in recent years (Table 3). The growing number of older patients has increased the number of lesions associated with malignant tumors (Table 4). Twenty years ago, Roper[7] observed that increased life expectancy results in more people surviving to the age at which malignant tumors are more common. Four of our seven patients over 70 years of age had malignant tumors.

Non-neoplastic causes of intussusception also have shifted markedly in sixty-five years (Table 3). Typhoid fever, tuberculosis, and dysentery were significant causes in 1911; they are rare in the United States today. Only two inflammatory lesions, one ileal and one appendiceal, were found among our 33 cases. Trauma was the assigned cause of intussus-

* Dr. Skandalakis is the Chris Carlos Professor of Surgical Anatomy and Technique, Professor of Anatomy and Assistant Professor of Surgery at Emory University School of Medicine. He is also Senior Attending Surgeon and Chairman of the Department of Postgraduate Education at Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta, Ga. 30309.

Dr. Atkin is Clinical Associate Professor of Surgery, Emory University School of Medicine, and Senior Attending Surgeon and Chief, McDonnell Surgical Center, Piedmont Hospital.

Drs. Harlaftis and Droulias are former Residents in Surgery at Piedmont Hospital. Dr. Gray is Professor of Anatomy, Emory University School of Medicine.

ception in over ten percent of patients in 1911. Roper,[7] reviewing cases from 1947 to 1952, found only 2.2 percent that could be so assigned. There were none in our series.

Meckel's diverticulum caused intussusception in one of our patients. A frequent cause in infants,[6] it becomes less common with age.

THE TWO-THIRDS RULE

The distribution of causes of intussusception in our 33 patients falls into a pattern which can be called the "two-thirds rule." The actual percentage at each level are given in parentheses:

Of all adults intussusceptions, two thirds are of known cause (66.7%); one third are idiopathic (33.3%).

Of intussusceptions with known causes, two thirds are of neoplastic origin (63.6%); one third are of non neoplastic causes (36.4%).

Of intussusceptions of neoplastic origin, two thirds are from malignant neoplasm (64.3%); one third are from benign neoplasms (35.7%).

This is a simple mnemonic rule; it serves to call attention to the relative incidence of the possible causes of intussusception. It applies to the present data only, and will need further confirmation.

LOCATION

The intussusception was enteric in 22 of the 33 cases, and colonic in eleven. This is a smaller proportion of colonic lesions than is usually reported.[9] The only retrograde (antiperistaltic) example was the intussusception of an efferent jejunum that suddenly passed through a long-standing gastrojejunostomy.

TABLE I

33 CASES OF INTUSSUSCEPTION IN ADULTS

Age and Sex	Site	Probable Cause	Duration of Symptoms (Days)	Diagnosed at	Treatment	Outcome
54 M	Jejunogastric	Idiopathic	<1	Small bowel series	Resection	Lived
17 F	Jejunojejunal	Idiopathic	3	Surgery	Reduction	Lived
22 F	Jejunojejunal	Idiopathic	None	Surgery	Reduction	Lived
26 M	Jejunojejunal	Idiopathic	None	Surgery	Reduction	Lived
54 M	Jejunojejunal	Malignant tumor	7	Autopsy	None	Died (cancer)
72 F	Jejunojejunal	Idiopathic	7	Surgery	Reduction	Lived
72 M	Jejunojejunal	Malignant tumor	3	Surgery	Resection	Died (after 2 recurrences)
77 M	Jejunojejunal	Idiopathic	1	Surgery	Resection	Lived
15 F	Jejunoileal	Benign tumor	3	Surgery	Resection	Lived
17 M	Jejunoileal	Adhesions	3	Surgery	Reduction	Lived
21 F	Jejunoileal	Idiopathic	1	Surgery	Reduction/ resection	Lived
32 M	Jejunoileal	Malignant tumor	60	Surgery	Resection	Died (melanoma)
23 F	Ileoileal	Malignant tumor	5	Surgery	Resection	Lived
24 M	Ileoileal	Adhesions	1	Surgery	Reduction	Lived
29 M	Ileoileal (mult.)	Idiopathic	90	Surgery	Reduction	Lived
29 F	Ileoileal	Idiopathic	7	Surgery	Reduction	Died (uremia)
40 F	Ileoileal	Benign tumor	3	Small bowel series	Resection	Lived
43 F	Ileoileal	Malignant tumor	14	Surgery	Resection	Lived
43 M	Ileoileal	Adhesions	4	Surgery	Resection	Lived
15 M	Ileocolic	Idiopathic	14	Barium enema	Resection	Lived
28 F	Ileocolic	Inflammation	3	Barium enema	Reduction/ resection	Lived
88 F	Ileocolic	Malignant tumor	60	Barium enema	Resection	Lived
31 F	Ileocecal	Benign tumor	3	Barium enema	Colectomy	Lived
31 M	Ileocecal	Meckel's	1	Surgery	Resection	Lived
83 F	Ileocecal	Malignant tumor	30	Surgery	Resection	Lived
85 M	Ileocecal	Benign tumor	4	Surgery	Resection	Lived
71 M	Cecocolic	Malignant tumor	1	Barium enema	Resection	Lived
39 F	Appendiceal	Inflammation	1	Surgery	Resection	Lived
48 M	Colocolic	Malignant tumor	28	Barium enema	Resection	Lived
54 M	Colocolic	Benign tumor	None	Autopsy	None	Died (perforated ulcer)
51 F	Sigmoidosigmoid	Hernia	?	Sigmoidoscopy	Resection	Lived
51 F	Sigmoidosigmoid	Idiopathic	270	Sigmoidoscopy	Reduction	Lived
68 F	Sigmoidosigmoid	Secondary to rectal prolapse	?	Surgery	Reduction	Lived

TABLE 2
CAUSES OF INTUSSUSCEPTION IN 33 ADULTS

Idiopathic (primary)		11
Benign tumors		5
Adenomatous polyp	3	
Lipoma	1	
Endometriosis of colon	1	
Malignant tumors		9
Adenocarcinoma	6	
Melanoma	2	
Plasmocytoma	1	
Inflammation		2
Meckel's diverticulum		1
Other		5
Adhesions	3	
Secondary to hernia	1	
Secondary to rectal prolapse	1	
Total		33

SYMPTOMS AND SIGNS

No single symptom is present in all patients with intussusception. Indeed, there were three asymptomatic cases in our series. The presenting symptoms in one were caused by a perforated ulcer, in another, by vascular compression of the duodenum, and in the third, the intussusception was found incidental to other abdominal surgery. The chief symptoms and clinical findings are shown in Table 5. Abdominal pain, localized or general, constant or crampy, was the most common symptom; obstruction, partial or complete, was the most frequent clinical sign. Intussusception accounts for about 5 percent of all intestinal obstruction.[2]

There are marked differences between the signs and symptoms in adults in the present series and those in our series of infants and children.[6] Pain and vomiting are slightly less common in adults, and intestinal bleeding occurs in only about one fourth of adults compared to almost all children with intussusception. Abdominal tenderness, uncommon in children, was found in over one half of adults with symptoms. A palpable mass was found in only 18 percent of our adult patients in contrast to 61 percent of infants and children (Table 6).

The symptoms of pain, intestinal bleeding and palpable mass commonly associated with infantile cases are seen much less frequently in adults with the disease.

Symptoms were present from one to three days in 14 patients, from four to seven days in six, from two to four weeks in four, and over one month in four patients. Three patients were asymptomatic, and the onset of symptoms was obscured by intercurrent disease in the remainder.

DIAGNOSIS

Intussusceptions in the colon or those extending into the colon were diagnosed in six patients by barium enema, in two by sigmoidoscopy, in three at surgery and one at autopsy.

The radiological picture of ileocecal or ileocolic intussusception is characteristic. Figure 1 shows a rounded, filling defect in the cecum indicating the presence of the intussusceptum. Figure 2 illustrates the "coiled spring" sign in the ascending colon. In figure 3, an ileocolic intussusception is seen producing a long filling defect in the transverse colon. All but two intussusceptions of the small intestine that did not reach the colon were diagnosed at surgery; two were diagnosed by gastrointestinal barium series, and one was found at autopsy.

TREATMENT

Simple reduction of the intussusception was performed in 11 of the 29 cases subjected to treatment. In another two, reduction was followed by resection. In the remaining 18 patients, resection without reduction was performed.

Simple reduction is tempting because it is often



Fig. 1—Ileocecal intussusception. There is a rounded filling defect in the cecum indicating the intussusception.

TABLE 3

ETIOLOGY IN CASES OF ADULT INTUSSUSCEPTION

Author	No. of Cases	Per Cent				
		Neoplastic		Non-neoplastic		
		Benign	Malignant	Meckel's	Other	Idiopathic
Eliot and Corscaden, 1911	213	25.8	14.6	6.1	18.3	35.2
Deterling et al., 1953	40	20.0	40.0	—— 5.0——		35.0
Roper, 1956	134	31.3	36.6	13.4	5.2	13.4
Dean et al., 1956	96	17.7	60.4	—— 9.4——		12.5
Weilbaecher et al., 1971	133	31.6	43.6	——10.5——		14.3
Present Series	33	15.2	27.3	21.2	3.0	33.3

immediately successful, it avoids entering the intestine with the associated danger of peritoneal contamination, and because, if unsuccessful, subsequent resection can be performed.

The risk of simple manual reduction was first pointed out in 1954 by Brayton and Norris[1] who called attention to the danger of dissemination of tumor cells by manipulation of colonic intussusceptions having malignant tumors at their leading points. Weilbaecher and his colleagues[9] have pointed out that the increasing number of malignant tumors found in the small intestine demands that the same care be taken with enteric intussusceptions. No patient in this series with a malignant tumor underwent manual reduction although two died of recurrence of their tumor following resection of the intussusceptions.

MORTALITY

Among our patients, the intussusception was found at autopsy in two. One of these patients died from reperforation of a previously repaired ulcer without symptoms of intussusception; the other died of neoplastic cachexia. Two died following recur-



Fig. 2—Ileocecal intussusception. The typical "coiled spring" sign in the ascending colon.

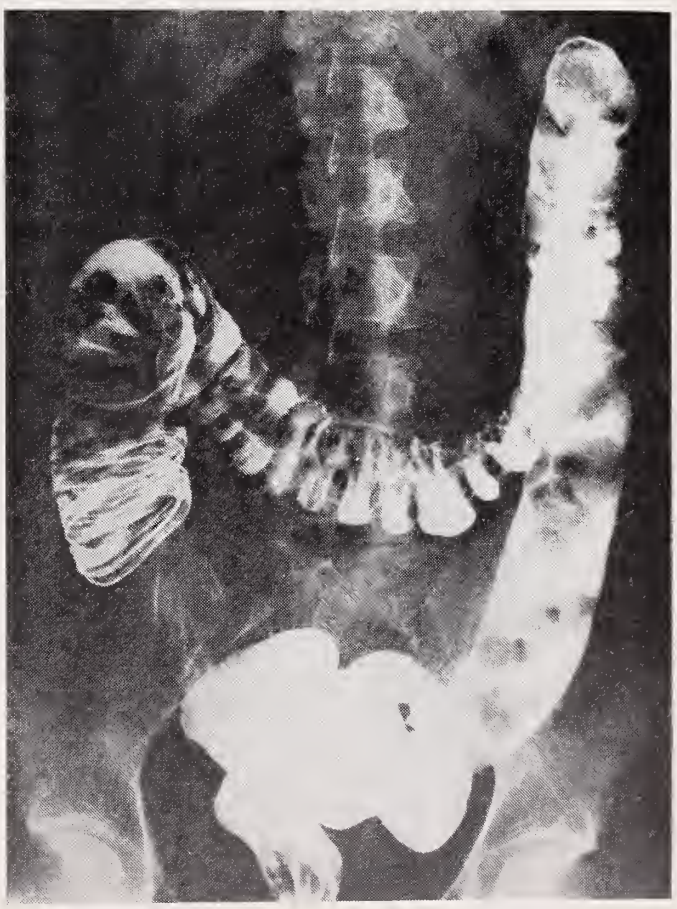


Fig. 3—Ileocolic intussusception. The leading point of the intussusception has reached the transverse colon. The barium has not reached the hepatic flexure.

Important.....

It may be a totally new experience for you or it may be the continuation of a secondary career.....

As a doctor in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found. . . . service to the community, state and nation.

In addition, many persons have found that the change of place and change of pace has resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for Georgia Army National Guard units. These "drill" periods, as we call them, can be very flexible to suit the needs and training requirements of the unit. Physicians even receive monetary support for attending CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS. If you need that CHANGE OF PLACE and CHANGE OF PACE, contact



Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662



TABLE 4

MEAN AGE AND CAUSE OF ADULT INTUSSUSCEPTION

Etiology	Mean Age in Years: Eliot and Corscaden 1911	Present Series
Benign tumor	39.2	45.0
Malignant tumor	43.9	57.1
Other	29.0	38.4
Meckel's diverticulum	27.1	31.0
Idiopathic (primary)	35.5	37.5

TABLE 5

INCIDENCE OF SYMPTOMS AND SIGNS IN 33 ADULT PATIENTS WITH INTUSSUSCEPTION

	Number of Patients
Symptoms	
Pain	20
Crampy, 11	
Constant, 9	
Vomiting	12
Nausea	11
Gastrointestinal bleeding	8
Diarrhea	5
Weight loss	2
Asymptomatic	3
Clinical Findings	
Abdominal tenderness	18
Abdominal distention	8
Abdominal mass	4
Rectal mass	2
Signs of partial or complete intestinal obstruction	13

TABLE 6

COMPARISON OF SYMPTOMS OF INTUSSUSCEPTION IN CHILDREN AND IN ADULTS

Symptoms	Per Cent: Children (159)*	Adults (33)
Pain	98.6	60.6
Vomiting	84.2	36.4
Gastrointestinal bleeding	93.1	24.2
Palpable mass	61.0	18.2
Abdominal distention	49.7	24.2
Abdominal tenderness	9.4	54.5

* Values from Lionakis, Gray, Skandalakis and Akin[6]

rence of the intussusception produced by a melanoma in one, and by a plasmocytoma in the other. A fifth patient died from uremia and postoperative bleeding. In three of the above cases the intussusception was caused by a malignant tumor; in one, by a benign tumor; and one death was the result of an idiopathic intussusception. The crude death rate was thus 15.2 percent. Excluding the first two deaths, the corrected rate was 9.1 percent.

In contrast, 34.3 percent of the 213 patients reported by Eliot and Corscaden[5] died, most of them immediately postoperatively. The greatest mortality was in the Meckel's diverticulum group.

SUMMARY

The pattern of intussusception in adults differs from that seen in infants. There are fewer idiopathic lesions and fewer caused by Meckel's diverticulum. Nearly half of the adult cases are caused by tumors, benign or malignant. The symptoms of pain, intestinal bleeding, and palpable mass commonly associated with infantile intussusceptions, are seen much less frequently in adults with the disease.

In the last 65 years there has been a marked increase in the age of adult patients with intussusception, and an increase in the number of cases caused by malignant tumors. Resection rather than simple reduction is recommended to avoid metastatic spread of malignant tumors by manipulation.

REFERENCES

1. Brayton, D. and Norris, W. J.: "Intussusception in Adults," *Amer. J. Surg.* 88:32-43, 1954.
2. Dean, D. L., Ellis, F. H. Jr., and Sauer, W. G.: "Intussusception in Adults," *Arch. Surg.* 73:6-11, 1956.
3. Deterling, R. A. Jr., O'Malley, R. D. and Knox, W.: "Intussusception in the Adult, with Emphasis on Retrograde Type," *Arch. Surg.* 67:854-864, 1953.
4. Donhauser, J. L. and Kelly, E. C.: "Intussusception in the Adult," *Am. J. Surg.* 79:673-677, 1950.
5. Eliot, E. Jr. and Corscaden, J. A.: "Intussusception with Special Reference to Adults," *Ann. Surg.* 53:169-222, 1911.
6. Lionakis, B., Gray, S. W., Skandalakis, J. E. and Akin, J. T.: "Intussusception in Infants and Children," *So. Med. J.* 53:1226-1235, 1960.
7. Roper, A.: "Intussusception in Adults," *Surg. Gyn. & O.* 103:267-278, Sept. 1956.
8. Stubenbord, W. T. and Thorbjarnarson, B.: "Intussusception in Adults," *Ann. Surg.* 172:306-310, 1970.
9. Weilbaecher, D., Bolin, J. A., Hearn, D. and Ogden, W. II: "Intussusception in Adults," *Am. J. Surg.* 121:531-535, May 1971.

- *Scientific programs in 16 specialties: Allergy and Immunology; Chest Disease; Emergency Medicine; Gastroenterology; Internal Medicine; Neurology; Neurosurgery; Nuclear Medicine; Ophthalmology; Pathology; Pediatrics; Plastic Surgery; Public Health; Psychiatry; Radiology; Surgery*
- *Interdisciplinary program on Asthma*
- *Educational Exhibits*

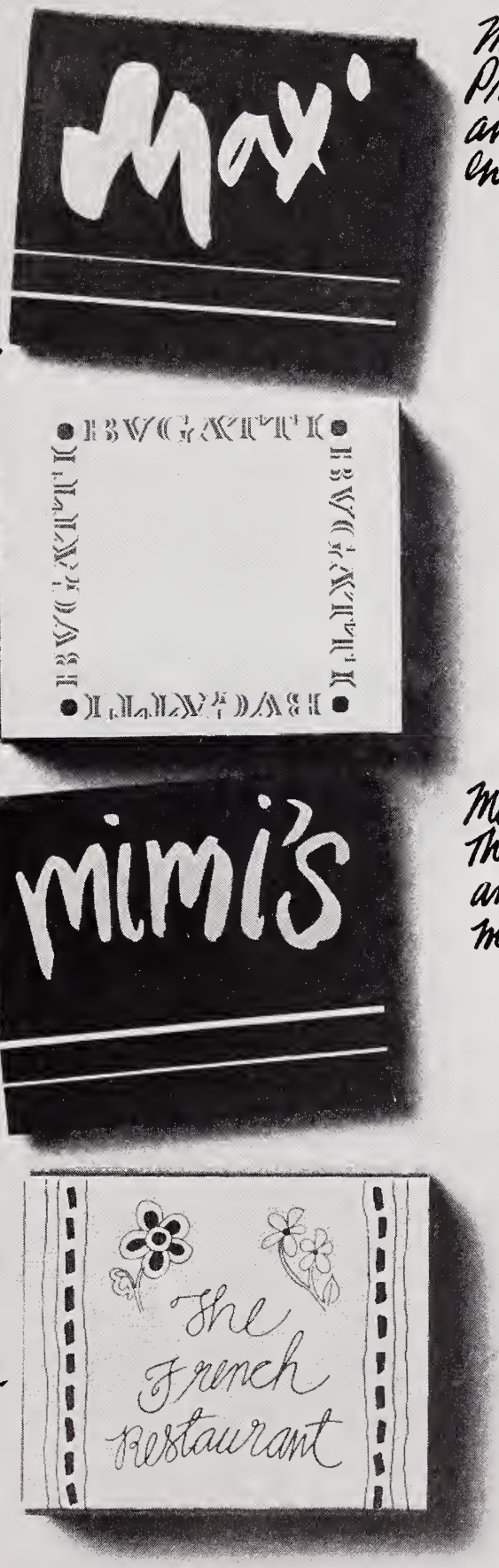
a pleasurable experience in continuing medical education

1977 MAG SCIENTIFIC ASSEMBLY

- *AMA Category 1 credit for all programs*
- *Luncheon and plenary session with a nationally-known guest speaker*
- *Alumni Night*

Omni International Hotel
downtown Atlanta
November 17-20, 1977

For details and registration information, write: 1977 Scientific Assembly, 938 Peachtree St., Atlanta, Ga. 30309, or call MAG, 404/876-7535 (toll free 1-800-282-0224 for long distance calls originating in Georgia).



Mix at Max'.
Prime beef, fresh seafood and late night live entertainment. 522-4442.

The most delightfully delicate dishes this side of the Appian Way. A fine Northern Italian restaurant and Club Bar. 659-0000.

Meet me at Mimi's.
The place to eat, drink and mix if the spirit moves you. 688-5900.

Superb, authentic Gallic cuisine in a garden-like setting. A Holiday Award-winning restaurant with a spirited French Bar. 659-0000.

Omni for all.

You'll find four of Atlanta's favorite restaurants all in one place.
Omni International, Techwood and Marietta Streets, downtown.

The Greek Healers: Asklepios, Hippocrates and Hygieia

STEPHEN W. GRAY, Ph.D., *Atlanta**

Some have regarded the myth of Asklepios as a prediction of Christ.

Hygieia stands as the symbol of physical and mental health.

Hippocrates looked at medicine as rational —something to be studied and discovered.

* Professor of Anatomy, Emory University School of Medicine, Atlanta, Ga. 30322.

With the accession of the Roman Emperor Constantine in the fourth century A.D., the age of paganism officially ended, and the worship of the Olympian gods, long on the decline, came to an end. Almost alone among these gods, Asklepios, the son of Apollo, survived.

In sharp contrast to the lives of most of the gods, the legends surrounding Asklepios contained no gross immorality, betrayal or scandal, only compassion for the sick. The Church Fathers could find no fault. Indeed, there was a strange parallel with the life of Christ. Asklepios, the son of a god, was born a man, practiced healing, died a man, and was resurrected as a god, forever present in his temples. At least one of the Church Fathers regarded the myth of Asklepios as a prediction of Christ.

Although Asklepios' shrines throughout the ancient world were finally closed, he remained a living tradition through the Middle Ages and into our own time. He continues to stand for the ever-recurring



Left to right: Hygieia, Asklepios, Hippocrates

miracle of restored health. Asklepios represents to us, as Carl Meier has said, not a quaint survival, but the persistence of a universal symbol in the human mind.

Hygieia is associated with Asklepios, often as his daughter, sometimes as his wife or his sister. She is also associated with Athena. As a young girl she stands as the symbol of physical and mental health.

The other side of medicine is represented by Hippocrates. Unlike the mythical Asklepios, Hippocrates was a historical person. He was born the son of an Asklepiad priest on the island of Cos in the fifth century B.C., the great century of Greek civilization. He was known to Plato and Aristotle. To Hippocrates, medicine was rational; it was something to be studied and discovered. He recognized that the experience of one physician was small and that case histories written down and freely communicated would provide an ever increasingly valuable basis for future therapeutic treatment.

So great was his influence that innumerable later medical writings were attributed to him by those who believed that their writings would be acceptable only if the reader believed they were written by Hippocrates.

Although Hippocrates was respected and almost deified, he was not emulated. The neglect of his rational approach to medicine emphasized his stature while debasing that of his admirers. His followers, with the exception only of Galen, wrote no case histories for 1700 years. The earliest manuscript left to us is of the tenth century A.D. and the first printed work of Hippocrates is dated 1526. It has been said that the last translation of Hippocrates' work for use by the physician was by Littré in 1839 and the first translation as history was that of Daremberg in 1851.

Neither Asklepian nor Hippocratic medicine depended on faith. The patient did not have to believe to be healed. He had only to be cooperative. "Even those who do not believe in it can be cured by it." (Hippocrates, *On the Art* 5.)

Antral and Pyloric Mucosal Diaphragm in Adults

STEPHEN W. GRAY, Ph.D., HENRY C. JOHNSON JR., M.D., *and*
JOHN E. SKANDALAKIS, M.D., Ph.D., F.A.C.S., *Atlanta**

A case study is discussed, concluding that mucosal diaphragms are not congenital in adults.

MUCOSAL MEMBRANOUS STENOSIS of the small intestine in infants is an uncommon but well-known congenital anomaly. Less frequently such stenoses are found in the stomach.[10, 14] Such membranes may be complete or they may have a central perforation. They usually present as acute obstructions soon after birth.

Similar perforated mucosal membranes have been described in the pylorus or antrum of the stomach in adults with a relatively short history of symptoms of partial obstruction. The origin of these diaphragms is not the same as that of the diaphragms of the newborn.

We have recently seen a patient who illustrates many of the features of this lesion.

CASE REPORT

A 79-year-old white female was admitted for morning fainting, epigastric discomfort and weight loss. On admission she was not in distress. Temperature was normal, pulse 90, BP 100/70, Hb 13.7, WBC 6300. The abdomen was soft with some RUQ tenderness but no rebound tenderness. Bowel sounds were not normal. She had a long history of chronic constipation, gas and eructation. She had been able to tolerate only liquids or baby foods for the last year, and had lost 50 lbs. in the past 5 or 6 years.

Chest X-ray showed emphysema; barium enema showed diverticulosis and diverticulitis of the sigmoid colon. An upper GI series in April 1971 showed irregularities in the duodenal cap and the antrum consistent with peptic ulcer scarring. A second series (May 1971) showed a circumferential constriction of the gastric antrum 2 cm proximal to the pylorus. The central opening was 4-5 mm in diameter. At the level of this ring there was a transient delay but no proximal dilatation or barium retention. The impression was congenital antral diaphragm.

A third series, one month later, showed narrowing of the antrum but no definite obstruction. She was considered a poor surgical risk and no operation was undertaken. On June 24, 1975, a distal antrectomy with Bilroth I anastomosis was performed. Because of postoperative failure of the stomach to empty, the patient was reoperated on July 10. Gastrojejunostomy was performed with a tube through the stomach into the efferent loop. She tolerated the operation satisfactorily, but the anastomosis did not function, and she died on the ninth postoperative day.

* Dr. Gray is Professor of Anatomy at Emory University School of Medicine; Dr. Johnson is Director of the Department of Radiology at Piedmont Hospital; Dr. Skandalakis is Chris Carlos Professor of Surgical Anatomy and Technique, Professor of Anatomy and Assistant Professor of Surgery at Emory University School of Medicine, and is Senior Attending Surgeon and Chairman of the Department of Postgraduate Education at Piedmont Hospital, 1968 Peachtree St., NW, Atlanta, Ga. 30309.

DISCUSSION

History and Incidence

With the exception of one report in 1879,[22] all cases have been reported since 1946. Gerber,[14] in 1965 was able to collect 29 cases from the literature. Sloop and Montague[41] found 33 cases in 1967 and McBee and North,[23] by 1970, recorded 47 cases. We have collected 66 cases through 1975 and added a case of our own (Table 1). Two of the cases were confirmed by gastroscopy only,[20, 43] one was found at autopsy[17] and one was reported from radiographic diagnosis only.[40] Curiously, although there were 16 reports in the decade 1950-59 and 43 in the decade 1960-69, very few reports have appeared since 1970.

A measure of the rarity of pyloric or antral diaphragms is that only one author has presented more than four adult cases. The exception presented eight cases[32, 33] and stated that he had seen over 40 such cases in eight years.[33] There are no other similar reports of such frequency.

Age and Sex

Tables 2 and 3 show the distribution of mucosal diaphragm by age, sex, and anatomical location. Thirty-five duodenal diaphragms from the papers of Smiley and his colleagues[42] and Cooperman and his colleagues[8] are included for comparison.

The patients with gastric diaphragms ranged in age from 20 to 84 years of age (Table 2). The median age was 56 years and over one half were in the sixth and seventh decades of life (Table 2). There were 29 males and 36 females; the difference is not statistically significant (Table 3).

There were 34 antral, 32 pyloric, and 35 duodenal diaphragms; age and sex distributions was similar. Rhind[33] believes that antral diaphragms are more readily discovered than are pyloric; there is probably a preponderance of pyloric lesions.

Anatomy

Gastric diaphragms involve only the mucosa and submucosa of the stomach; the muscularis externa is not involved. There is usually no external evidence of their presence. They are 3 to 4 mm thick at the gastric wall, becoming thinner at the aperture. In a few cases in which the diaphragm was incised, it collapsed and became indistinguishable from the surrounding tissue.[2, 12] Where the antrum and pylorus were removed and fixed for pathological study, the diaphragm retained its shape. The aperture may be central or eccentric. Size was measured in 34 of the patients. It was less than 5 mm in diameter in 25 patients and 5 mm or larger in nine (Table 4). It should be remembered that the normal pyloric opening is 17 to 19 mm in diameter.[37] In one patient with a longstanding gastroduodenostomy, there was no aperture in the diaphragm.[33]

About half the patients had gastric ulcers or ulcer scars. In one patient, aberrant pancreatic tissue was present in the diaphragm.[24] In some patients there is scarring of the edge of the aperture, and the gastric musculature proximal to the stenosis is often hypertrophied.[41]

Symptoms

The symptoms of antral or pyloric mucosal diaphragm are those of partial obstruction. Vomiting, epigastric pain or tenderness, and weight loss are the most frequent. In some patients there were episodic attacks, increasing in frequency and severity with



Fig. 1—Mucosal diaphragm of the gastric antrum. The lesion shows as a "knife cut" defect that remains in the same position on successive films.

TABLE 1

CASES OF ANTRAL OR PYLORIC MEMBRANOUS STENOSIS IN ADULTS

Author	Date	Sex and Age	Antrum or Pylorus	Duration of Symptoms
Landerer[22]	1879	M 44	A	—
Albot et al.[1]	1946	M 32	P	3 years
Sames[38]	1949	F 40	A	6 years
Gross & Durham[16]	1953	F 35	A	several yrs.
Rota[35]	1953	F 74	P	8 years
Passalaqua and Romero[29]	1955	M 62	P	12 years
Swartz and Shepard[47]	1956	F 55	A	2 years
Bariéty[3]	1957	M 52	A	4 months
Chamberlain and Addison[6]	1959	F 55	P	8 months
Chamberlain and Addison[6]	1959	M 52	P	3 years
Rhind[32]	1959	F 38	P	4 years
Rhind	1959	M 59	P	5 weeks
Rhind	1959	F 59	P	3 years
Rhind	1959	M 70	A	23 years
Rhind	1959	M 47	P	1 year
Rhind	1959	M 60	P	3 years
Rhind	1959	M 54	P	6 years
Rowling[33]	1959	M adult	P	12 years
Rowling	1959	M 68	A	18 years
Melamed et al.[25]	1960	M 62	A	2 days
Spencer[44]	1961	M 53	P	4 months
Young[48]	1961	F 53	P	several yrs.
Kenny[21]	1962	F 53	P	10 years
Kenny	1962	F 49	P	12 years
Kenny	1962	F 65	P	9 months
Kenny	1962	F 65	P	several yrs.
Popesco-Urlueni[30]	1962	F 45	P	3 years
Bergeron and Bourdeix[4]	1963	M 71	P	40 years
Munro[26]	1963	M 56	A	8 months
Singer[40]	1963	F 80	A	10 years
Stahl[45]	1963	F 62	P	15 years
Browning[5]	1964	M 62	A	10 years
Conway[7]	1965	F 29	A	5 years
Diethrich and Regan[11]	1965	F 64	A	1 year
Gibbon & Ashby[15]	1965	-55	A	5 years
Itzes[19]	1965	M 69	P	many years
Pulsifer et al.[31]	1965	F 59	P	25 years
Rhind[33]	1965	M 62	P	—
Sokol et al.[43]	1965	F 31	A	long history
Parrish et al.[28]	1966	F 54	A	many years
Schwartz et al.[39]	1966	F 74	A	20 years
Banks et al.[2]	1967	F 62	A	12 years
Robinson[34]	1967	M 56	P	whole life
Sloop and Montague[41]	1967	F 41	A	2 months
Strange[46]	1967	F 49	A	6 years
Strange	1967	F 54	A	1 month
Strange	1967	F 62	P	9 years
Strange	1967	F 47	P	5 years
Creedon[9]	1968	F 72	P	12 months
Creedon	1968	M 53	A	30 years
Farnum et al.[12]	1968	M 61	P	8 years
Farnum et al.	1968	F 79	P	7 years
Halliday et al.[17]	1968	M 58	A	3 months
Halliday et al.	1968	F 62	P	Autopsy
Katz[20]	1968	M 38	A	1 year
Parrish et al.[27]	1968	F 56	A	6 months+
Parrish et al.	1968	F 67	A	10 months
Parrish et al.	1968	M 59	A	2 years
Felson et al.[13]	1969	M 78	A	3 years
Felson et al.	1969	M 74	A	2 years
Felson et al.	1969	M 41	P	18 years
Felson et al.	1969	F 84	A	40 years
McBee and North[23]	1970	M 55	A	20 years
Irwin[18]	1971	F 20	A	8 years?
Manier[24]	1971	F 65	A	1 year
Present case	1975	F 75	A	7 years

TABLE 2

AGE AT DISCOVERY OF ANTRAL PYLORIC AND DUODENAL MUCOSAL DIAPHRAGM

Age (Years)	Pyloric	Antral	Duodenal*
20-29	—	2	4
30-39	2	3	5
40-49	5	5	5
50-59	10	10	4
60-69	10	7	7
70-79	4	5	5
80-89	—	2	—
Not given	1	—	5
	32	34	35

* Data from Smiley et al. and Cooperman et al.

TABLE 3

SEX DISTRIBUTION OF ANTRAL, PYLORIC AND DUODENAL MUCOSAL DIAPHRAGM

	Male	Female	Unknown	Total
Pyloric	15	17	—	32
Antral	14	19	1	34
Duodenal*	15	15	5	35
	44	51	6	101

* Data from Smiley et al. and Cooperman et al.

TABLE 4

SIZE OF APERTURE FOUND IN GASTRIC MUCOSAL DIAPHRAGM

Size	Number
None	1*
1-2 mm	12
3-4 mm	12
5-6 mm	5
7-8 mm	2
9-10 mm	2

* The patient had a long standing gastroduodenostomy (Rhind 1965).

TABLE 5

DURATION OF SYMPTOMS OF ANTRAL AND PYLORIC MUCOSAL DIAPHRAGM BEFORE DIAGNOSIS

Duration	Number
Less than 1 year	12
1-4 years	15
5-9 years	12
10-14 years	7
15-19 years	3
20 + years	7
"Several" or "many" years	6
"Whole life" (56 years)	1
Unknown	3
Total	66

time.[2] Eating habits may become modified, as was the case in our own patient, yet weight loss continues.

The radiologic picture is typical, with a persistent "knife cut" defect in the antrum or pylorus (Figure 1). Gross enlargement with delayed emptying may be present.[9] The first preoperative diagnosis by X-ray seems to be that of Melamed and his colleagues in 1960.[25] Since then, eight patients have been correctly diagnosed by radiology. In at least 12 patients, the typical appearance was present, but was recognized only in retrospect after operation. In most of the remaining cases the X-ray diagnosis was non-specific.

The diaphragms are probably the result of stasis of gastric contents, rather than being the cause of the obstruction.

In five patients, the diaphragm was observed and recognized by gastroscopy.[2, 7, 20, 24, 43]

The duration of symptoms was reported in 56 of the sixty-six patients (Table 5). The median age of these patients was 59 years; the median duration of symptoms was 6 years. The shortest duration was two days;[25] the longest was 40 years in a 71-year-old patient.[4] In only one case were the symptoms reported to have existed from birth.[34]

ETIOLOGY

The two major views of the origin of these mucosal diaphragms have been:

1. They are congenital malformations resulting from failure of the intestinal lumen to become recanalized after a transient solid stage of the embryonic foregut.[28, 41, 47] In most patients, the diaphragm causes obstruction in infancy; in a few, it perforates and permits the passage of sufficient food until late middle age when poor chewing habits[14] and weakened musculature[27] suddenly combine to make stomach emptying difficult.

2. The mucosal diaphragms of infancy are congenital defects. Adult diaphragms result from ulcer scars.[9, 12, 31, 32]

We cannot agree with the first hypothesis. We are unable to believe that a congenital diaphragm having an aperture of a few millimeters (Table 4) could permit normal or nearly normal gastric emptying for 50 years (Table 5) only to produce obstruction late in life.

We agree with the second view that the diaphragms in adults are acquired. Some may be due to ulcer scars, but, while ulcers are often present, they are probably the result of stasis of gastric contents rather than being the cause of the obstruction.

We believe that the diaphragms in adults are formed by movements of the gastric mucosa prolapsing caudally to form a circular fold of mucosa at the antrum or pylorus. Under the pressure of gastric contents, more mucosa is added concentrically to the fold until it forms a typical diaphragm with a small central aperture. Sometimes during its development, which may take months or even years, symptoms of partial obstruction begin. In one case[17] there was no evidence of a diaphragm 12 years before its actual discovery. We believe that this hypothesis fits the clinical data and that these mucosal diaphragms in adults, unlike those in infants, are not of congenital origin.

TREATMENT

Subtotal gastrectomy has been the operation of choice for the majority of the patients reported in this series. In some cases the mucosal diaphragm was recognized only on pathological examination of the specimen.

In a few patients, excision of the membrane with pyloroplasty has been successful.[26, 27, 34, 36] The line of the excision should be closed longitudinally to avoid circumferential scarring. This procedure has been used more frequently in infants than in adults.[41]

PROGNOSIS

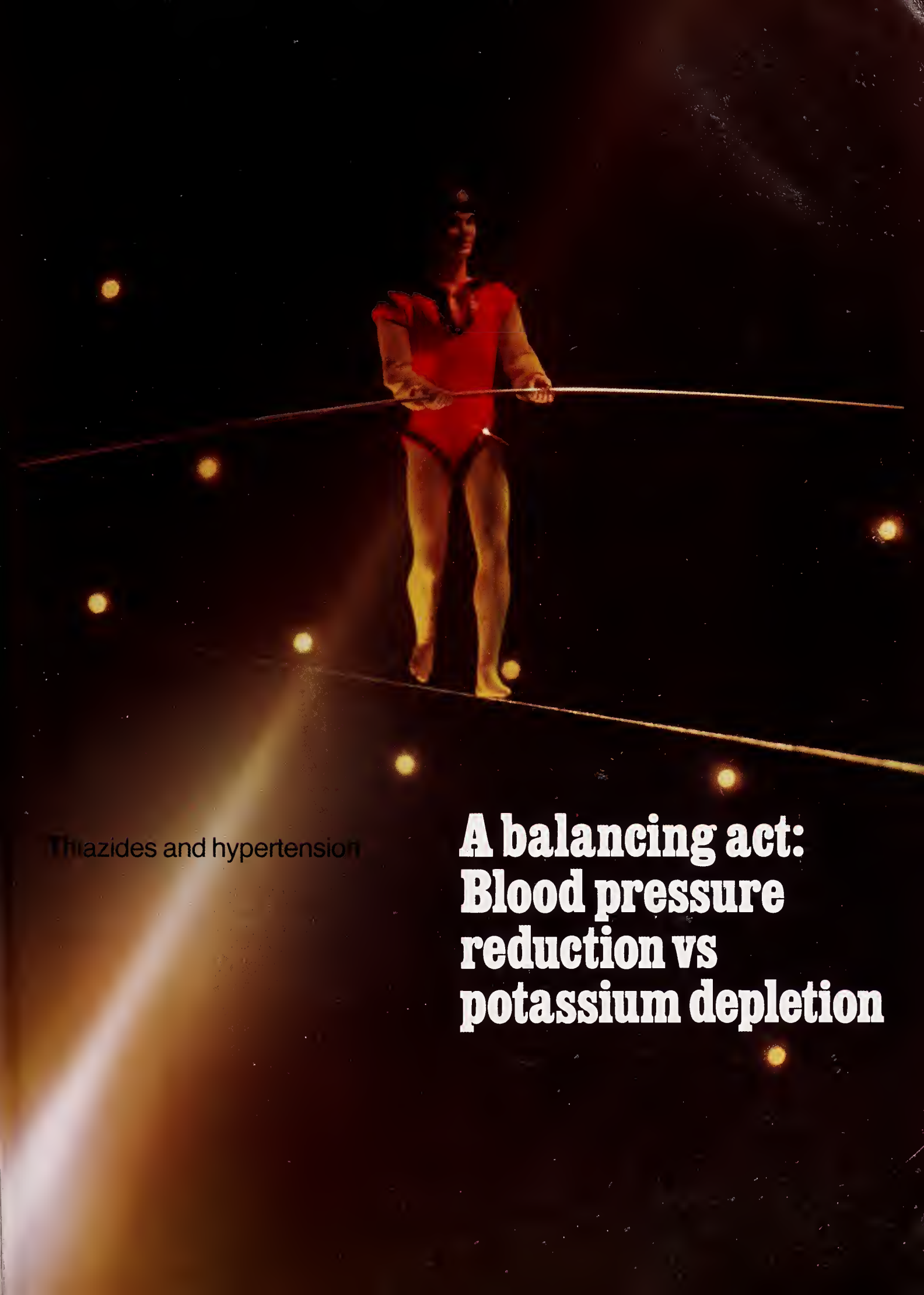
The prognosis for the relief of symptoms is good. Three patients have died following operation[30, 32] since 1946 including our own patient.

SUMMARY

A case of an antral mucosal diaphragm causing stenosis in a 79-year-old woman is presented and the literature on antral and pyloric diaphragms in adults is reviewed. It is concluded that, in adults, mucosal diaphragms are not congenital, but acquired, as a type of concentric mucosal prolapse shortly before they manifest symptoms.

REFERENCES

1. Albot, G., Renaux, J. and Girard, E.: "Atrophique Ulcereuse avec Etranglement de l'antre Pre-Pylorique par un Diaphragm," *Arch. Mal. Appar. Dig.* 35:118, 1946.
2. Banks, P. A., Waye, J. D., Waitman, A. M. and Cornell, A.: "Mucosal Diaphragm of the Gastric Antrum," *Gastro.* 52:(6) 1003-1008, 1967.
3. Bariéty, M., Poulet, J. and Courtois-Suffit, M.: "Diaphragme Muqueux Preplyroique et Cancer Bronchique Primitif Problemes de Diagnosic Poses par cetti Coexisence," *Presse Med.* 65:785, 1957.
4. Bergeron, A. and Bourdeix, G.: "Stenose du Pylore par Diaphragme Muqueux," *Arch. Mal. Appar. Dig.* 52:575, 1963.
5. Browning, R. W.: "Prepyloric Antral Mucosal Diaphragm or 'Webb,' " *Amer. Surg.* 30:73, 1964.
6. Chamberlain, D. and Addison, N. V.: "Adult Pyloric Obstruction Due to a Mucosal Diaphragm: Report on Two Cases," *Brit. Med. J.* 2:1381, 1959.
7. Conway, N.: "Pyloric Antral Mucosal Diaphragm," *Brit. Med. J.* 1:970-971, 1965.
8. Cooperman, A. M., Adachi, M., Rankin, G. B. and Sivak, M.: "Congenital Duodenal Diaphragm in Adults," *Ann. Surg.* 182:739-742, 1975.
9. Creedon, F.: "Adult Pyloric Mucosal Diaphragm," *Brit. J. Surg.* 55:818-822, 1968.
10. Cremin, B. J.: "Congenital Pyloric Antral Membranes in Infancy," *Radiology* 92:509-512, 1969.
11. Diethrich, E. B. and Regan, W. J.: "Antral Mucosal Diaphragm Associated with Esophogeal Hiatus Hernia," *Am. J. Surg.* 110:482-486, 1965.
12. Farnum, J., Cywes, S. and Werbeloff, L.: "Pyloric Mucosal Diaphragms," *Clin. Radiol.* 19:95-99, 1968.
13. Felson, B., Berkmen, Y. M. and Hoyumpa, A. M.: "Gastric Mucosal Diaphragm," *Radiology* 92:513-517, 1969.
14. Gerber, B. C.: "Prepyloric Diaphragm: An Unusual Abnormality. A Case Report." *Arch. Surg.* 90:472-480, April 1965.
15. Gibbon, N. O. K. and Ashby, W. B.: "Pyloric Antral Mucosal Diaphragm," *Brit. Med. J.* 1:1496, 1965.
16. Gross, K. E. and Durham, M. W.: "Pyloric Antral Mucosal Diaphragm—Report of a Case," *Radiology* 61:368, 1953.
17. Halliday, J. P., Jelihovsky, T. and Stephen, D.: "Pyloric Antral Membrane," *Aust. New Zeal. J. Surg.* 37:363-365, 1968.
18. Irwin, J. W.: "Chronic Obstruction of the Antrum of the Stomach by a Mucosal Diaphragm with Malnutrition Impairment of Growth and Secondary Small Intestine Damage," *Ulster Med. J.* 41:39-44, 1971.
19. Itzes, E.: "Discussion Paper of Gerber," *Arch. Surg.* 90:480, 1965.
20. Katz, L. A.: "Asymptomatic Mucosal Diaphragm of the Gastric Antrum: Report of a Case," *Gastroint. Endosc.* 15:106-107, Nov. 1968.
21. Kenny, P. J.: "The Adult Pyloric Diaphragm," *Aust. and New Zeal. J. Surg.* 32:270, 1962.
22. Landerer, H.: "Ueber aneborene Stenose des Pylorus," *Dissertation,* Universitat Freiburg, Tubingen, 1879.
23. McBee, J. W. and North, L. B.: "Antral Mucosal Diaphragm in the Adult," *Gastroint. Endosc.* 16:196-200, May 1970.
24. Manier, J. W.: "Antral Mucosal Diaphragm Containing Pancreatic Tissue," *Gastroint. Endosc.* 17:146-148, May 1971.
25. Melamed, A., Haukohl, R. S. and Callan, R. E.: "Pyloric Antral Mucosal Diaphragm with Transpyloric Mucosal Prolapse," *Radiology* 74:452-457, 1960.
26. Munro, A. I.: "Prepyloric Mucosal Diaphragm," *Brit. J. Surg.* 50:981, 1963.
27. Parrish, R. A., Kanavage, C. B., Wells, J. A. and Moretz, W. H.: "Congenital Antral Membrane," *Surg. G. & O.* 127:999-1004, 1968.
28. Parrish, R. A., Sherman, H. S. and Moretz, W. H.: "Congenital Antral Membrane," *Surg.* 59:681-684, 1966.
29. Passalaqua, L. A. and Romero, C. A.: "Partial Obstruction of the Pylorus Due to a Mucosal Diaphragm of Congenital Origin," *Bol. Asoc. Med. P. Rico* 47:211, 1955.
30. Popesco-Urluieni, M., Bacalou, L. and Mayer, S.: "Syndrome Du Diaphragme Muqueux Antro-Pylorique," *Arch. Mal. Appar. Dig.* 51:1535, 1962.
31. Pulsifer, L., Jedd, F. L. and VanZandt, T. F.: "Pyloric Obstruction by a Mucosal Diaphragm," *Am. J. Gastroent.* 43:30-34, 1965.
32. Rhind, J. A.: "Mucosal Stenosis of the Pylorus," *Brit. J. Surg.* 46:534, 1959.
33. Rhind, J. A.: "Pyloric Antral Mucosal Diaphragm," *Brit. Med. J.* 1:(2) 1309, 1965.
34. Robinson, K. P.: "Pyloric Stenosis Due to a Mucosal Diaphragm," *Brit. J. Surg.* 54:397-399, 1967.
35. Rota, A. N.: "Pyloric Obstruction Due to Mucosal Diaphragm," *Arch. Path.* 55:223, 1953.
36. Rowling, J. T.: "The Prepyloric Septum: A Rare Anomaly," *Brit. J. Surg.* 47:162, 1959.
37. Salessiotis, N.: "Measurement of the Diameter of the Pylorus in Man. Part I. Experimental Project for Clinical Application," *Amer. J. Surg,* 124:331-333, Sept. 1972.
38. Sames, C. P.: "A Case of Partial Atresia of the Pyloric Antrum Due to a Mucosal Diaphragm of Doubtful Origin," *Brit. J.* 37:244, 1949.
39. Schwartz, I. R., Hirsch, E., Mule, J. E. and Bluestone, L.: "Antral Mucosal Diaphragm Clinical and Roentgen Characteristics, with First Reported Case of Vibrio Fetus in Human Bile," *Am. J. Gastroent.* 45:366-373, 1966.
40. Singer, M.: "Pyloric Antral Mucosal Diaphragm," *J. Newark Beth Israel Hosp.* 14:131-136, April 1963.
41. Sloop, R. D. and Montague, A. C. W.: "Gastric Outlet Obstruction Due to Congenital Pyloric Mucosal Membrane," *Ann. Surg.* 165:598-604, 1967.
42. Smiley, K., Perry, M. and McClelland, R.: "Congenital Duodenal Diaphragm in the Adult; Review of the Literature and Report of a Case," *Ann. Surg.* 165:632-636, 1967.
43. Sokol, E. M., Shorofsky, M. A. and Werther, J. L.: "Mucosal Diaphragm of the Gastric Antrum," *Bull. Gastroint. Endosc.* 12:20-21, 1965.
44. Spencer, S. L.: "Adult Pyloric Obstruction Due to a Mucosal Diaphragm," *Med. J. Aust,* 1:816, 1961.
45. Stahl, W. M. Jr.: "Unusual Pyloric Obstruction in an Adult; Congenital Partial Diaphragm of Pylorus," *JAMA* 186:1173, 1963.
46. Strange, S. L.: "Prepyloric and Pyloric Mucosal Stenosis," *Proc. Roy. Soc. Med.* 60:1-3, 1967.
47. Swartz, W. T. and Shepard, R. D.: "Congenital Mucosal Diaphragm of the Pyloric Antrum," *J. Kentucky Med. Asso.* 54:149, 1956.
48. Young, H. B.: "Addisonian Pigmentation Due to Extreme Pyloric Stenosis by a Mucosal Diaphragm," *Brit. J. Surg.* 49:104, 1961.



Thiazides and hypertension

A balancing act: Blood pressure reduction vs potassium depletion

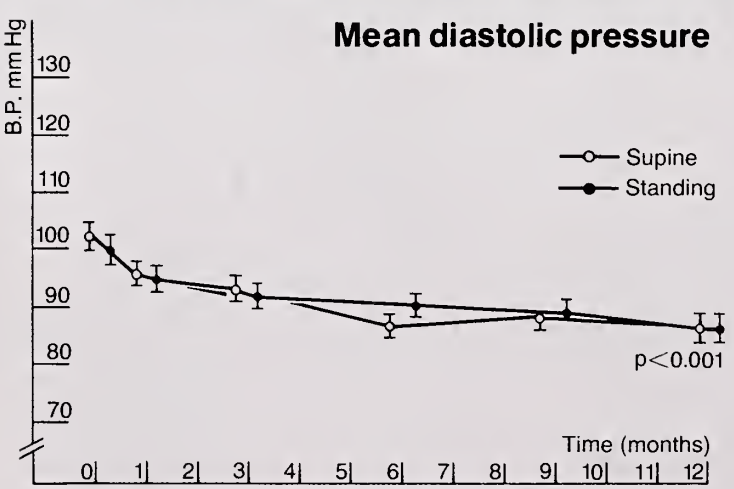
From a 1-year study of 18 patients with mild uncomplicated hypertension published in The Lancet*

Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

Diastolic blood pressure down 12-15%



"The mean pretreatment blood pressure was 170/103 mm Hg (supine) and 166/100 mm Hg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88 mm Hg (supine) and 142/88 mm Hg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762, 1975.



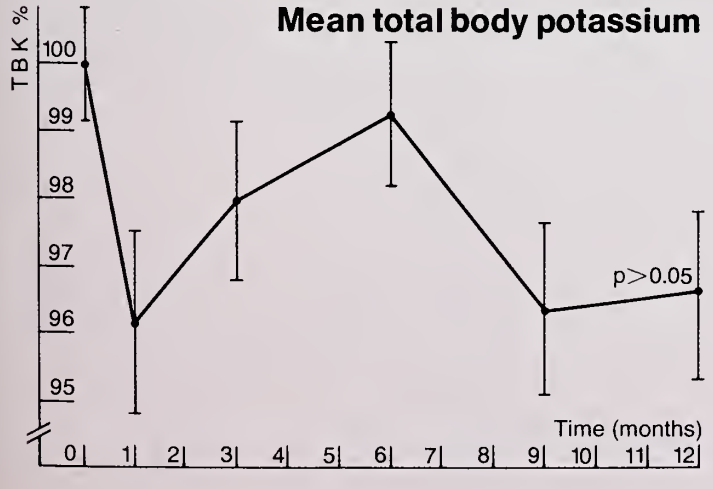
Once a day

Naturetin®

Bendro-flumethiazide Tablets N.F.

2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5 mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0 mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day Naturetin®

Bendroflumethiazide Tablets N.F.

NATURETIN®-2.5
NATURETIN®-5
NATURETIN®-10
Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis. *Central Nervous System:* dizziness, vertigo, paresthesia, headache, and xanthopsia. *Hematologic:* leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia. *Dermatologic-Hypersensitivity:* purpura, photosensitivity, rash, urticaria, and necrotizing angiitis (vasculitis, cutaneous vasculitis). *Cardiovascular:* orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. *Other:* hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

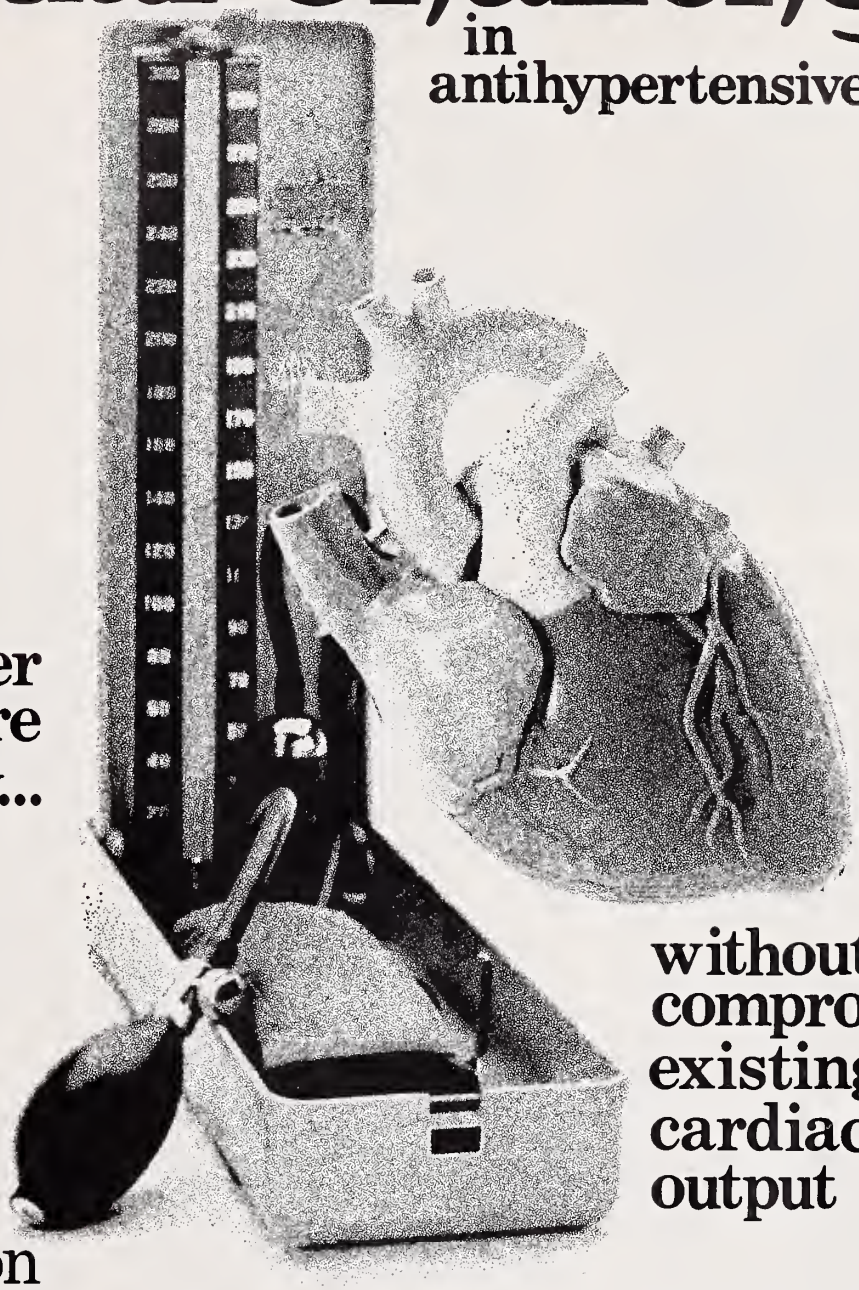
2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

SQUIBB®

©1977 E.R. Squibb & Sons, Inc. 477-501

A Dual Challenge

in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

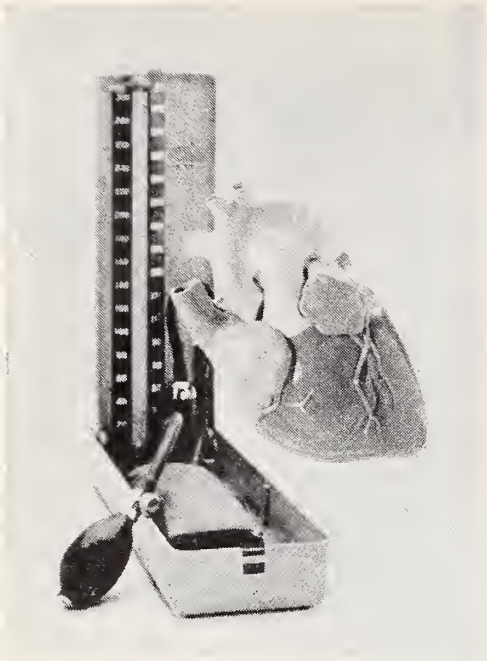
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07(707)

MSD MERCK SHARP & DOHME

Medical Meeting Calendar

AUGUST

15-19—*Atlanta;* **ACP-MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM IV;** Category 1 Credit; Contact: American College of Physicians, 4200 Pine St., Philadelphia 19104.

15-20—*Cashiers, NC;* **SMOKY MOUNTAIN SUMMER SEMINAR;** Category 1 Credit; Contact: Assoc. Dean of CME, Emory School of Medicine, 69 Butler St., Atlanta 30303, PH: 659-1676.

21-22—*Milwaukee, WI;* **NATIONAL CONFERENCE ON HEALTH CARE IN JAILS** (sponsored by AMA); Contact: Frank Chappell, 312/751-6606, home 312/644-2426, or write: AMA Jail Project, AMA, 535 N. Dearborn St., Chicago 60610.

22-26—*Birmingham;* **ACP-MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM IV;** Category 1 Credit; Contact: American College of Physicians, 4200 Pine St., Philadelphia 19104.

28-Sept. 1—*Atlanta;* **AMERICAN HOSPITAL ASSOCIATION MEETING;** Contact: Mr. Edmond J. Lanigan, Dir., Bureau of Conventions & Meetings, 840 N. Lake Shore Dr., Chicago 60611.

SEPTEMBER

8-11—*Hilton Head, SC;* **BORDERLINE CONDITIONS;** Category 1 Credit; Contact: Georgia Psychiatric Assoc., c/o Harold L. McPheeters, MD, 130-6th St., NW, Atlanta 30313.

15—*Atlanta;* **FIFTH ANNUAL CARDIAC REHABILITATION WORKSHOP;** Contact: Gerald F. Fletcher, MD, Dir. of Internal Medicine, Georgia Baptist Medical Center, 300 Blvd., NE, Atlanta 30312.

16-17—*Lexington, KY;* **FIBEROPTIC BRONCHOSCOPY WORKSHOP;** Category 1 Credit; Contact: Frank R. Lemon, MD, College of Medicine, Continuing Education, University of Kentucky, Lexington, KY 40506.

16-18—*Atlanta;* **GEORGIA HEART ASSOCIATION'S 29TH ANNUAL MEETING AND SCIENTIFIC SESSIONS;** Category 1 Credit; Contact: Georgia Heart Assoc., 2581 Piedmont Rd., NE, Atlanta 30324.

17-21—*New Orleans;* **ACP-MEDICAL KNOWLEDGE SELF-ASSESSMENT PROGRAM IV;** Category 1 Credit; Contact: Amer. College of Physicians, 4200 Pine St., Philadelphia 19104.

23-Oct. 1—*London, Paris;* **OBSTETRICS AND CLINICAL ENDOCRINOLOGY,** Presented by School of Medicine, Medical College of Ga., Contact: Div. of Continuing Education, Medical College of Georgia, Augusta, Ga. 30901.

24-25—*Callaway Gardens, GA;* **CARDIOPULMONARY RESUSCITATION,** sponsored by Ga. Soc. of Anesthesiologists & Medical College of Georgia, Category 1 Credit; Contact: Z. W. Gramling, MD, Talmadge Memorial Hospital, Augusta 30902.

29-30—*Atlanta;* **CLINICAL CARE OF RHEUMATIC DISEASES;** Category 1 Credit; Contact: Samuel B. Chyatte, MD, Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory Univ. School of Medicine.

30-Oct. 1—*Gainesville, FL;* **MEDICAL ASPECTS OF AGING;** Category 1 Credit; Contact: Mr. Bill Rockwood, Coordinator, University of Fla., Div. of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville, FL 32610, PH: 904/392-3143.

OCTOBER

2-7—*Lexington, KY;* **EIGHTH FAMILY MEDICINE REVIEW, SESSION I;** Category 1 Credit; Contact: Frank R. Lemon, MD, Continuing Education, College of Medicine, University of Kentucky, Lexington, KY 40506.

3-4—*Chattanooga;* **TENNESSEE VALLEY MEDICAL ASSEMBLY;** Category 1 Credit; Contact: Chattanooga, Hamilton County Medical Sociaty, Chattanooga.

3-7—*Augusta;* **FAMILY PRACTICE SYMPOSIUM;** Category 1 Credit; Contact: Div. of Continuing Education, Med. College of Ga., Augusta 30901, PH: 404/828-3967.

3-14—*Correspondence Course;* **PRIMARY CARE FOR THE NEWBORN, 1977 SECOND EDITION;** Category 1 Credit; Contact: Ga. Academy of Family Physicians Educational Foundation, Miss Camille Day, Exec. Dir., 11 Corporate Square, Suite 205, Atlanta 30329, PH: 404/321-7445.

5-8—*Atlanta;* **ANNUAL MEETING AMERICAN ACADEMY OF CEREBRAL PALSY;** Category 1 Credit; Contact: Executive Dir., 1255 New Hampshire Ave., NW, Washington, DC 20036.

12-13—*Atlanta;* **FALL MEETING, GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS;** Category 1 Credit; Contact: James W. Bennett, 1467 Harper St., Augusta 30902.

15-19—*New Orleans;* **AMERICAN SOCIETY OF ANESTHESIOLOGISTS;** Category 1 Credit; Contact: J. W. Andes, 515 Busse Hwy, Park Ridge, IL 60068.

16-18—*Gatlinburg, TN;* **CANCER CONCEPTS 1977: CARE OF MELANOMAS AND NON-HODGKINS LYMPHOMAS;** Category 1 Credit; Contact: Dr. Harvey Goodman, Dept. of Continuing Medical Education, University of Tennessee Center for the Health Sciences, 1924 Alcoa Hwy., Knoxville 37920, PH: 615/971-3345.

17-23—*Atlanta;* **AMERICAN SOCIETY OF CLINICAL HYPNOSIS;** Contact: W. F. Hoffman, 2400 E. Devon Av., Suite 218; Des Plaines, IL 60018.

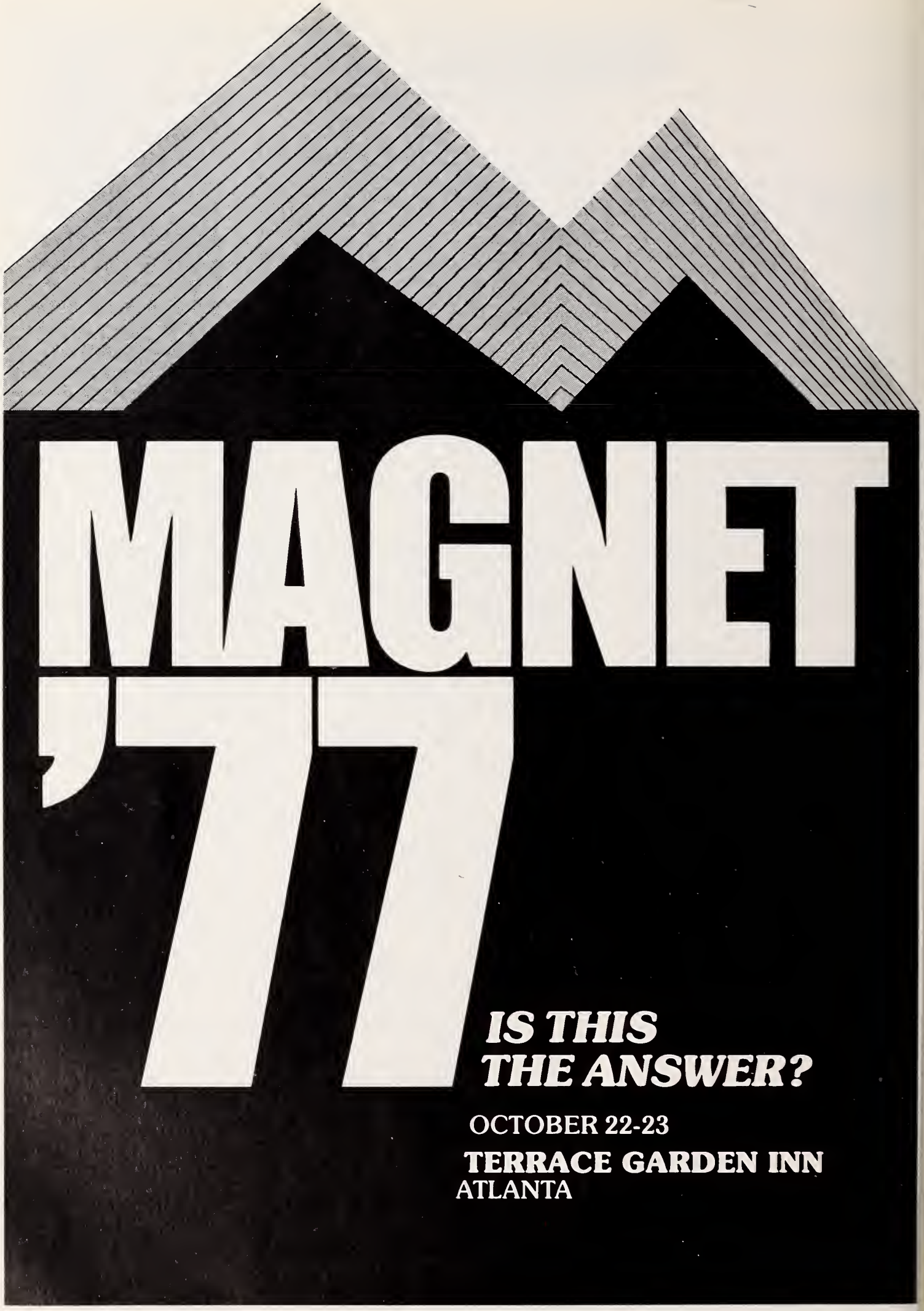
20-23—*New Orleans;* **AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW;** Contact: W. D. Weitzel, MD, Dept. of Psychiatry, College of Medicine, University of Kentucky; Lexington, KY 40506.

23-29—*Lexington, KY;* **EIGHTH FAMILY MEDICINE REVIEW: SESSION II;** Category 1 Credit; Contact: Frank R. Lemon, MD, Continuing Education, College of Medicine; University of Kentucky, Lexington, KY 40506.

28-29—*Callaway Gardens, GA;* **1977 CME SEMINAR ON INFECTIOUS DISEASES** (for PAs); Contact: Physician Associate Program, Div. of Allied Health Professions, Emory University School of Medicine, P.O. Box 22095, Atlanta 30322.

30-31—*Atlanta;* **AMERICAN COLLEGE OF PREVENTIVE MEDICINE;** Category 1 Credit; Contact: W. Bentley, 801 Old Lancaster Road, Bryn Mawr, PA 19010.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.


MAGNET
'77
IS THIS
THE ANSWER?
OCTOBER 22-23
TERRACE GARDEN INN
ATLANTA



TERRACE GARDEN INN...

You'll Open Your Mouth Wide and say, "Ah-h-h, It's Beautiful!"

- Enjoy our luxurious rooms and suites.
- We're in a Prime Location—across from 200 stores including Neiman-Marcus, Saks Fifth Avenue, Lord & Taylor, Tiffany, Rich's.
- We're in Atlanta's prettiest residential and business area... and right off I-75-85.
- Dine in our dramatic, multi-level GARDENTREE RESTAURANT.
- For a fast bite, there's our bright, cheerful SUN FLOWER Coffee Shop.
- Play tennis on our professional courts with complete locker facilities. Rental equipment, too.
- Swim in our beautiful, cascading tiered pool.
- Have FUN in our Corner Hearth Lounge with live entertainment nightly (except Sunday).

Call Collect 404/261-9250 for reservations

Terrace Garden Inn
3405 Lenox Road Atlanta, Ga. 30326

Primary Adenocarcinoma in an Elongated Fallopian Tube

JACK SORG, M.D., *and* ERNEST M. CURTIS, M.D., *Atlanta**

PRIMARY ADENOCARCINOMA of the fallopian tube is an uncommon disease, rarely diagnosed before surgery. In the case here presented, the diseased tube reached unusually large dimensions with virtually no symptoms. The purpose of this paper is to report this peculiar pathology and to review the presentation and management of this disease entity.

Adenocarcinoma of the fallopian tube is a rare entity; here a most unusual case is discussed.

Case Report

A 53-year-old multiparous patient was thought to have a left ovarian cyst on pelvic examination during an episode of cystitis, but was lost to follow up for three months. She returned complaining of vague pelvic aching, and was seen in consultation by one of us (E.C.). Her menstrual flow continued at monthly intervals without intermenstrual discharge. There was no history suggestive of pelvic inflammatory disease. On examination she was obese and was thought to have a 7-centimeter moderately firm cystic mass to the left of a nodular uterus of similar size. Vaginal cytology was unremarkable.

At exploratory laparotomy, the most striking finding was a markedly elongated, convoluted, fluid-filled, left fallopian tube, 28 cm long by 4 cm in greatest diameter (Figs. 1, 2). Its serosal surface was smooth and glistening with a few filmy adhesions, and without excrescences. The clubbed distal end surrounded a normal ovary. The right oviduct had a similar appearance, but was smaller, measuring 11 cm in length by 2 cm greatest diameter. Its clubbed distal end was attached to a normal-appearing ovary. Neither tube had definite palpable intrinsic tumor. There were no palpable lymph nodes, no peritoneal nor omental nodules, no palpable liver pathology and no ascites. No spillage of tubal contents was seen before or during a total abdominal hysterectomy and bilateral salpingo-oophorectomy.

Pathologic examination revealed a left tubal lumen filled with fluid and papillary excrescenses up to 1.5 cm in diameter. Microscopic study showed well differentiated adenocarcinoma involving the mucosa, but without apparent extension to the serosal layer. The right tube displayed a benign hydrosalpinx. Small intramural leimyomata were present in the uterus. Both ovaries were normal.

Postoperatively, the patient did well and was discharged on the seventh day. She began a course of chemotherapy several weeks later of Alkaran, 8 mg daily for 5 days every 6 weeks during a 9-month

* Dr. Sorg is Chief Resident in Surgery and Dr. Curtis is Attending Surgeon, Department of Obstetrics and Gynecology, Piedmont Hospital, 1968 Peachtree Rd., NW, Atlanta, Ga. 30309.

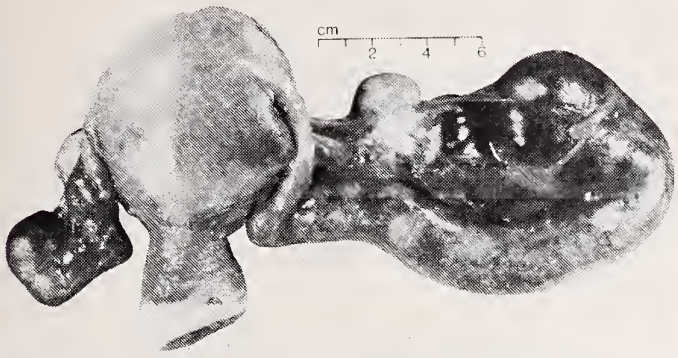


Fig. 1—Photograph of specimen, showing bilateral hydrosalpinx, left much greater than right.

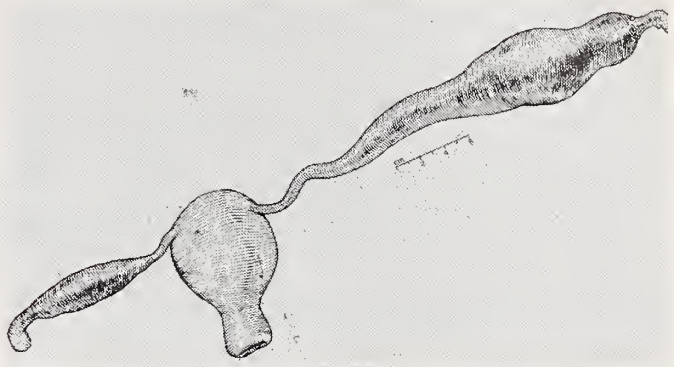


Fig. 2—Artist's concept of specimen with both tubes freed of adhesions and pulled out to full length.

period. She has no sign of pelvic tumor at laparoscopy one year after the diagnosis.

Comments

Several aspects of this case are quite typical of primary adenocarcinoma of the oviduct. The patient's age was close to the reported mean age of 52 years, although the range is from 18 to 80 years.[1] An adnexal mass was palpable; but the correct preoperative diagnosis was not made.[2] There was an associated contralateral hydrosalpinx with occlusion of the fimbriated end.

Atypical aspects of this case were her multiparity, the absence of pain, and her continued regular, normal periods in spite of her age.

Of particular interest was the marked elongation of the fallopian tube. The longest previously reported tube was 24 cm.[3] This length was probably not a normal variant, but the result of the particular type of hydrosalpinx that tubal cancer causes. It is not known whether other causes of hydrosalpinx can cause this type of preferential elongation rather than dilatation.

Total abdominal hysterectomy with bilateral salpingo-oophorectomy is the standard basis of treatment for this disease. To this may be added either chemotherapy or irradiation,[4] although the rarity of adenocarcinoma of the tube makes it difficult to establish clearly the value of each.[5] A second look with laparoscopy, for instance, may be indicated for the evaluation of therapy. The overall survival rate has been reported at about 34 to 40 percent,[2] and appears to be related to the degree of extension of tumor into or through the oviduct wall.[6]

Summary

Adenocarcinoma of the fallopian tube is a rare entity usually first diagnosed at laparotomy, even when the full triad of symptoms—mass, pain, and bleeding—is present. The case here presented is even more unusual because of the remarkable length of the oviduct.

In the absence of any suggestion of extension beyond the primary site, treatment consisted of total abdominal hysterectomy, bilateral salpingo-oophorectomy, chemotherapy, and "second look" laparoscopic confirmation of the results one year later.

REFERENCES

1. Kistner, Robert W.: *Gynecology* (2nd Ed.). Chicago: Year Book Medical Publishers Inc., 1971, pg. 315.
2. Jones, O. Vaughn: "Primary Carcinoma of the Uterine Tube," *Obstet. & Gynec.* 26:122, 1965.
3. Lombardo, Francis A. and Wood, Harry T.: "Primary Adenocarcinoma of the Uterine Tube," *Obstet. & Gynec.* 17:611, 1961.
4. Griffiths, C. Thomas: "Ovary and Fallopian Tube." *Cancer Medicine,* James F. Holland and Emil Frei III, eds. Philadelphia: Lea and Febiger, 1973.
5. Momtazee, Samad and Kempson, Richard L.: "Primary Adenocarcinoma of the Fallopian Tube," *Obstet. & Gynec.* 32:649, 1968.
6. Schiller, Herbert M. and Silverberg, Steven G.: "Staging and Prognosis in Primary Carcinoma of the Fallopian Tube," *Cancer* 28:389, 1971.

Invest in Rare Silver

Rare medallic history of the United States. 200 large solid sterling silver medals, each with history of a different year. Over 8 years to assemble and complete.

Each medal is individually hallmarked to certify that it is solid sterling silver. Each medal of this rare First Edition Proof Set has serial number which will be registered in your name to provide excellent protection. One of only a relatively few sets minted in this brilliant Proof condition.

Special purchase price. Purchase now and receive valuable bonus collection. For information, call

261-4902

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

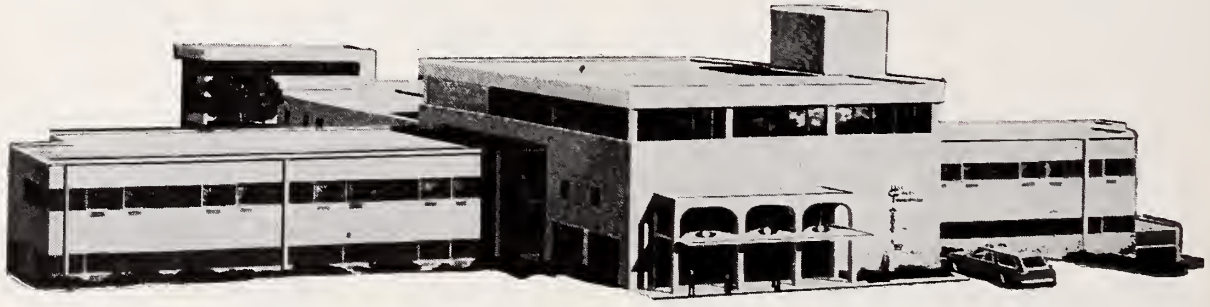
W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Hill Crest
HOSPITAL

Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.

Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION:* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company



Only 1 tablet B.I.D.

New convenience

Gantanol® DS

sulfamethoxazole/Roche

double-strength dosage form for acute cystitis* patients

*nonobstructed; due to susceptible organisms

New Gantanol® DS (sulfamethoxazole) tablets offer even greater convenience and economy for your patients with acute, nonobstructed cystitis due to susceptible strains of *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*...

- The same amount of medication, the same efficacy, with only *half* the number of tablets per day.
- Simplified dosage regimen encourages patient compliance: 2 tablets (1 Gm each) STAT—then 1 tablet B.I.D. for 10 to 14 days.
- Clinical efficacy so basic you can start cystitis therapy even before culture results are available.
- In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

and economy

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially; then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Basic therapy with convenience and economy:

Gantanol® (sulfamethoxazole)Roche®

Basic therapy with even more convenience and economy:

Gantanol® DS (sulfamethoxazole)Roche®

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

YOU MAKE THE CHOICE.



EMPIRIN® COMPOUND w/ CODEINE #3

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

C-III

EMPRACET™ w/ CODEINE #3

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

C-III

Wellcome | **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

editorials
editorials
editorials

Piedmont, a Community Hospital, Alive and Well

THIS ISSUE of the *Journal* features scientific papers written by members of the house staff and attending staff of Piedmont, a non-profit community hospital in Atlanta. Since the community hospital constitutes the foundation of our superior hospital care in this country, it seems appropriate to highlight such a hospital occasionally in the *Journal*.

Founded in 1905 with a capacity of ten beds and housed in a converted family residence, it has grown progressively to its present capacity of 419 beds. Among these are a general intensive care unit, respiratory intensive care unit, gastrointestinal unit, a coronary care unit, and an 84-bed extended care facility. A special arthritis unit is to be opened soon. In addition to the general surgical operating rooms, there is a separate center for minor surgical procedures not requiring an overnight hospital stay.

Besides a Department of Diagnostic Radiology, which includes a total body scanner and nuclear medicine laboratory, there is a separate Department of Radiotherapy with its linear accelerator to complement complete cobalt facilities.

The Department of Pathology operates a superior clinical laboratory and supervises one of the few schools for laboratory technologists in the city.

The hospital operates a 24-hour emergency room service staffed entirely by attending staff and surgical house staff. A Department of Social Service is maintained and fills a great need. A modern physical therapy facility is housed within the hospital.

The hospital has its own in-house educational T.V. station which has been very effective in helping hospitalized patients keep abreast of health care topics.

An extensive medical library is supervised by a certified medical librarian.

An active renal dialysis facility, a peripheral vascular laboratory and a laser eye treatment facility are all maintained within the hospital.

As Piedmont grew, so did its School of Nursing, organized soon after the hospital was founded. The education building and students' residence situated on the hospital grounds were completed in 1961.

A Women's Auxiliary provides thousands of hours of volunteer help each year in addition to sponsoring fund-raising projects for the benefit of the hospital.

In 1973, a new 80-physician professional building was added to the hospital complex.

Among the more attractive features offered by this community hospital to its staff members are the ten to twelve clinical conferences each week. These con-

ferences embrace the major medical specialties. Frequent outside speakers lend variety to the programs which are attended by attending staff, house staff and graduate and student nurses.

An approved surgical residency program has been in operation for many years. This is supervised by a member of the Emory faculty. Beginning in July, a medical residency program will be activated in cooperation with Emory University. For many years, Emory has maintained an active cardiology program at Piedmont supervised by a member of the full-time faculty of the Department of Medicine. Cardiac fellows at Emory have a two months' rotation through the Piedmont program.

In spite of allegations that our system of medical care is actually a fragmented "non system," the well-run community hospital stands in sharp rebuttal to such a charge. Only in such a setting can the specific needs of an individual community be met. Support your local hospital!

Edgar Woody Jr., M.D
Editor

Letters to the Editor

Dear Sir:

The May 1977 issue of the Journal "WHAT PRICE HEALTH?" is excellent. It should be widely distributed, particularly to those who say that physicians are not concerned or interested in reducing the cost of medical care.

I would like to suggest one additional recommendation to Dr. Rogers' committee and to all those on Utilization Review committees. In addition to the question "Was this hospitalization necessary?," ask also "Could this illness have been prevented? If so, why wasn't it prevented?"; eg: children with measles or mumps, adults with strokes or heart failure due to untreated hypertension, acidosis and coma in diabetics who never had dietary counseling, cancer of the cervix in women who have never had a Pap smear.

Where has the system failed? Was it poor communication between doctor and patient? Did the patient have reasonable access to medical care? Did the patient purposely fail to comply with medical directions—if so, why? These questions have not been adequately studied by insurance, government, labor or organized medicine.

Yet if preventable diseases and complications are truly prevented using our present knowledge, I think there would be not only decreased costs but decreased suffering and fewer premature deaths—which is really the "bottom line."

Sincerely,
JOSEPH A. WILBER, M.D.
Atlanta

Dear Dr. McDaniel:

The stories you write published in the Medical Journal of Georgia ("I've Told This Before") are interesting and full of good humor. I have read them every time they appear and I hope you continue to write them.

Sincerely,
J. DEWEY GRAY, M.D.
Augusta

president's letter



1977 Scientific Assembly

ALTHOUGH THIS is July, it is not too early to make your plans to attend the annual MAG Scientific Assembly, to be held November 17-20 at the Omni International Hotel in Atlanta.

I am very pleased to announce to you that 16 specialty societies will be represented this year, some for the first time.

Compliments are due our Committee on Scientific Assembly as well as staff for their continuing work to provide for us a fine, growing program. The programs at the Assembly will be approved for AMA Category 1 credit, which may be used in making application for the Physician's Recognition Award and for meeting CME requirements in your specialties.

For these benefits, I urge each and every one of you to attend if at all possible. I know there will be something there for everyone—so y'all come now, you hear!

Cordially,

Robert E. Perry Jr. M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia

I've told this before . . .

(Editor's Note: Dr. Kellum recalls a time when, as an intern, his improvisation was misunderstood. Others wishing to contribute to this page should send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Called on the Carpet, But Not Electrocuted

When I was an intern at the "Gradies," each of us had to serve a month, making sick calls in the ambulance. On one of my first calls, the patient was an elderly man with complete urinary retention, due to benign prostratic hypertrophy. The urology ward was filled and overflowing. I had been instructed not to admit any more.

I tried to pass a catheter, but it wouldn't go. Central supply had failed to include a catheter-guide in my sterile catheter kit. So, I called to his wife to bring me a wire coat-hanger and some pliers, which she did, and then excused herself. After fashioning a guide from the coat-hanger, I successfully passed the catheter, giving him relief, but causing a little bleeding.

When I returned to the hospital, I was summoned to the Medical Director's office. I couldn't imagine what he wanted with me. He was a *stern* fellow. "I was shaking in my boots." As I entered his office, he began chuckling, and told me he had just had a complaint from my urology patient's wife—saying I had catheterized her husband with a coat-hanger and a pair of pliers, causing him to bleed and have much pain.

J. Morgan Kellum, M.D.
Thomaston, Ga. 30286

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.
Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with Low St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

going into practice ? consider north carolina

North Carolina's Office of Rural Health Services Offers You:

—the chance to discuss practice opportunities in 60 communities from the coast to the mountains

—the opportunity to work with physician extenders if you so desire

—the chance to join a group, partnership, association or to establish a new practice

—the opportunity for you and your spouse to visit a community with the right kind of life-style and medical practice organization

—the opportunity to participate in the North Carolina Area Health Education Centers Program

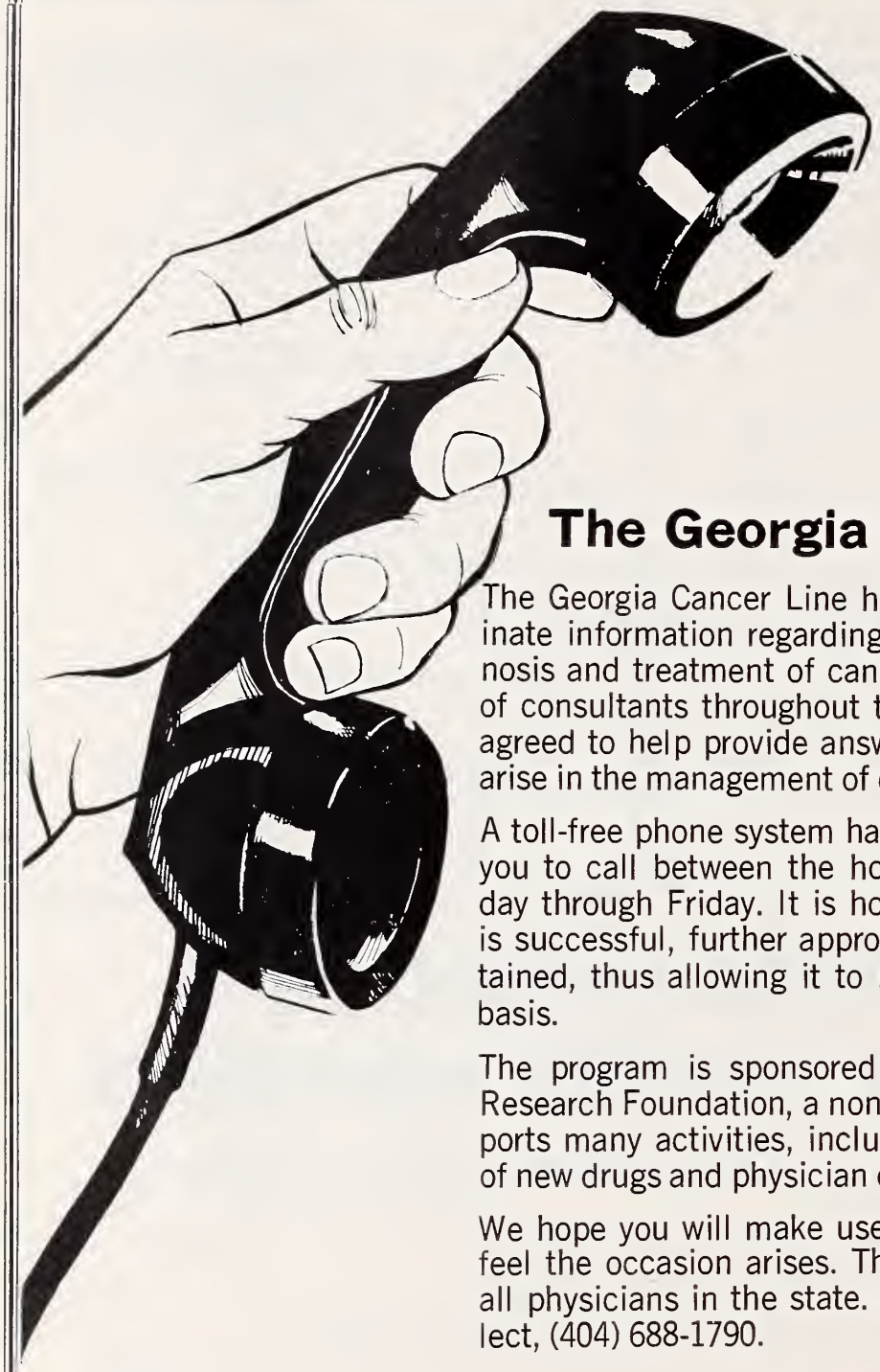
The Office of Rural Health Services Has Information On 60 Communities For Your Consideration

Please Send Me More Information About North Carolina

Office of Rural Health Services
Department of Human Resources
Box 12200
Raleigh, N. C. 27605

Name _____ (First / Middle / Last)
Address _____ (Street)
_____ (City / State / Zip Code)
Date Available _____
Home Phone _____ Work Phone _____

☐ Family Practice
☐ Internal Medicine
☐ OB/GYN
☐ Pediatrics
☐ Emergency Room
☐ _____



The Georgia Cancer Line

The Georgia Cancer Line has been developed to disseminate information regarding recent advances in the diagnosis and treatment of cancer. We have enlisted a group of consultants throughout the state of Georgia who have agreed to help provide answers to questions which might arise in the management of cancer cases.

A toll-free phone system has been set up which will allow you to call between the hours of 9 am and 5 pm, Monday through Friday. It is hoped that if this pilot program is successful, further appropriate sponsorship can be obtained, thus allowing it to be continued on a permanent basis.

The program is sponsored by the Southeastern Cancer Research Foundation, a non-profit organization which supports many activities, including clinical research, testing of new drugs and physician education projects.

We hope you will make use of this system whenever you feel the occasion arises. The Cancer Line is available to all physicians in the state. All you have to do is call collect, (404) 688-1790.

Sponsored by
The Southeastern Cancer Research Foundation
P.O. Box 54777, Atlanta, Ga. 30308
(404) 688-1790

Call Collect

(404) 688-1790

Tempest in the "Sugar" Bowl

This timely editorial is reproduced from the bi-monthly publication of the American Cancer Society, Kansas Division, Inc. and the Mid-American Cancer Center Program, "CANCER CONTROL FOR THE PROFESSIONAL," Frederick H. Holmes, M.D., Editor.—**LaMar S. McGinnis, M.D., Chairman, Professional Education Committee, American Cancer Society, Georgia Division, Inc.**

One can't help but pity the Food and Drug Administration of our government for having to navigate between the Scylla of subtle environmental carcinogens on the starboard side and the Charybdis of laissez faire economics on the port side. However, one wonders if anyone at the FDA in Washington read the study of the British Diabetic Association about the lack of correlation of saccharin use and cancer in British diabetics.

Considering that saccharin has been in use for decades, one presumes that the FDA research included population-based (people) studies. If not, it certainly should have, as such information is easily obtained. Nevertheless, consider the British experience:

"Risk of cancer was not found to increase with relatively high levels of saccharin ingestion among 5,971 members of the British Diabetic Association who were followed for five to eight years. Data collected by Armstrong, et al., of London, England, indicated that more than half of the diabetics studied used saccharin tablets daily with an overall daily intake of three to six tablets, depending on sex and age. Of 1,207 deaths that occurred among the BDA members studied, 128 died from cancer, which was fewer than the expected 168 deaths from the mortality of the population of England and Wales in 1972. The authors attributed this low rate to a deficit in the number of deaths from cancer related to smoking. Of the survivors in this study, a small sample indicated that about 23% of them would have taken saccharin daily for ten years or more and 10% for 25 years or more by the end of the follow-up."—(Br. J. Prev. Med. 30:151-157 (Sept.) 1976 SO)

Rumor has it that much of the data for the FDA decision to ban saccharin was obtained from rodent experiments done in Canada. When one recalls that the British didn't stampede into a Swine Flu program either, but elected to wait and watch (us?), perhaps we have something to learn from their conservative approach to public health. We may have gotten our advice from the wrong part of the British Commonwealth in respect to saccharin and cancer.

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society, 2025 Peachtree Rd., N.E., Atlanta, Ga. 30309.

heart page
heart page
heart page

The Evolution of Prosthetic Heart Valves

DOUGLAS C. MORRIS, M.D., *Atlanta**

THE ERA OF PROSTHETIC VALVES began in September 1952, with the implantation of a caged-ball prosthesis in the descending aorta by Hufnagel.[1] This particular prosthesis met with limited success in that it kept some of its recipients alive until improved prostheses were available. More satisfactory prostheses became generally available in 1964 with the introduction of the 1000 series Starr-Edwards aortic valve and the 6000 series Starr-Edwards mitral valve. Dr. Albert Starr had first successfully implanted a caged-ball prosthesis in the mitral position on September 12, 1960.[2] Harken and his associates had previously reported in May, 1960, five cases of aortic valve replacement with only one survivor.[3]

The subsequent history of prosthetic valves has revolved around modification of the original Starr-Edwards' ball-valve design, alterations of construction material, and introduction of new valve designs. The impetus for these changes has been dissatisfaction with the hemodynamic characteristics, durability, and thrombogenicity of previously available prostheses.

The early models of the Starr-Edwards' valve were plagued by a very high incidence of thromboembolism and reports of ball variance. (Poppet variance refers to prosthetic valve dysfunction resulting from physical and chemical alteration in the poppet.) These complications led respectively to cloth covering of, first, the valve annulus and, finally, the annulus and the cage, and replacement of the silastic poppet with a stellite poppet. Unacceptable gradients across the completely cloth-covered valves subsequently led to the introduction of the composite seat valves. This model allows the stellite poppet to sit upon metal studs protruding through the cloth covered annulus.

The conventional disc prostheses were developed to overcome the problems of poppet-inertia and ventricular-prosthetic disproportion. These problems were occasionally associated with implantation of a caged-ball prosthesis in the mitral position. By employing a lightweight disc as an occluder, poppet-inertia and the length of the cage were both reduced in these "low-profile" disc prostheses.

Recognition that all central-occluder prostheses (either conventional ball or disc valves) were characterized by moderate to marked transvalvular gradients

* Co-Director of the Carlyle Fraser Heart Center and Assistant Professor of Medicine—Cardiology, Emory University School of Medicine. Dr. Morris' address is Crawford W. Long Memorial Hospital, Agnes Raoul Glenn Building, 25 Prescott St., N.E., Atlanta, Ga. 30308.

led to the development of the tilting disc models. In these models, the occluding disc pivots to an opening angle of 60-80° allowing for a central flow of blood across the prostheses. These prostheses are likened to a toilet seat and its cover with the disc swinging open from the annulus. The latest models of this design, the Bjork-Shiley and Lillehei-Kaster valves, have been found to have the lowest transvalvular gradients of all prostheses currently available.

In spite of the advancements made, the problem of thromboembolism has never been completely eliminated with any of the mechanical prostheses. Clearly, recent design modifications have decreased the problem of thromboembolism; however, only with adequate anticoagulation is the incidence of thromboembolism in mechanical prostheses insignificant. The cloth-covered valves (Beall disc valve, Starr-Edwards 2310-2320 ball valves) and the central flow tilting disc valve (Bjork-Shiley) have reported incidence of thromboembolism of less than 5% over 1-5 years follow-up on anticoagulation.[4, 5, 6] Bonchek and Starr had no occurrences of emboli among 116 patients with the 2310-2320 Starr-Edwards prostheses receiving Coumadin versus 23 thromboembolic events in 134 patients not receiving Coumadin.[4] Javier and associates found the incidence of embolization in their patients with Beall valves was four times more frequent when the patients were not treated with anticoagulants.[6a]

It was this problem of thromboembolism which served as the stimulus for the implantation of various types of tissue valves. Presently, at various centers valve replacement is being performed with heterografts, homografts, and autografts. While degenerative changes in the valve cusps leading to late valve failure have dampened the enthusiasm for homografts in the U.S., reports from groups outside the United States using fresh antibiotic-treated homografts[7, 8, 9] suggest a reduced incidence of valve failure compared with that of chemically treated or irradiated valves. Utilization of autologous pulmonary valves for aortic valve replacement is essentially confined to the surgical team headed by Donald Ross at Guy's Hospital, London, England.[10] The uncertainty about degenerative valve failure coupled with the elaborate surgical technique of transposing the pulmonary valves and, in turn, replacing them with an aortic heterograft has limited the widespread acceptance of this approach.

The most widely utilized tissue valve is a composite tissue valve composed of porcine aortic leaflets mounted on a flexible stent. This prosthesis developed by Hancock Laboratories was first clinically implanted in the mitral position in February, 1969. The reported incidence of embolization with this prostheses regardless of position is 1.7% over 4½ years.[11] The only apparent disadvantages with the heterograft valve are a larger transvalvular gradient than with comparable size tilting-disc valves and uncertaintly as to its long term durability.

In summary, the four considerations to be given before selecting a particular prosthesis are its hemodynamic parameters, the associated incidence of thromboembolism, the durability, and the patient acceptability. Unquestionably, the hemodynamic parameters of the tilting-disc model is superior to the other available prostheses. With regards to thromboembolism, the mechanical prostheses can approach the very low incidence found with the tissue valves only if the patient is adequately anticoagulated. Durability has been firmly established only for the non-cloth covered ball valve. Strut cloth wear has necessitated re-operation in some cloth-covered ball valves[4] and the design modifications to reduce this problem are too recent to assess. Similiarly, further follow-up is needed to determine the durability of the tilting disc valve and, especially, the tissue valves. Patient acceptability of a prosthesis is primarily dependant on the audibility of valve sounds and acceptance of long-term anticoagulation. The tissue valves are the only prostheses whose closing sounds will predictably be inaudible, while among the currently available mechanical prostheses the composite-seat Starr-Edwards valve generally emits the most noise.

Our present approach, based on the low incidence of thromboembolism, is to

use the Hancock porcine heterograft in the mitral and aortic positions. The exception to this policy is the use of the Bjork-Shiley valve in patients with a small aortic root. Our preference for the tilting disc valve in this circumstance is based on the smaller gradients across this prosthesis.

BIBLIOGRAPHY

1. Hufnagel, C. A., Harvey, W. P., Rabil, P. J., McDermott, T. F.: "Surgical correction of aortic insufficiency." *Surgery* 35:673-683, 1954.
2. Starr, A., Edwards, M. L.: "Mitral replacement: clinical experience with a ball-value prosthesis." *Ann. Surg.* 154:727-740, 1961.
3. Harken, D. E., Soroff, H. S., Taylor, W. J., Lefemine, A. A., Gupta, S. K., Lunzer, S.: "Partial and complete prostheses in aortic insufficiency." *J. Thor. Cardiovasc. Surg.* 40:744-762, 1960.
4. Bonchek, L. I., Starr, A.: "Ball value prostheses: current appraisal of late results." *Am. J. Cardiol.* 35:843-854, 1975.
5. Reid, J. A., Stevens, T. W., Sigwart, U., Fulweber, R. C., Alexander, J. K.: "Hemodynamic evaluation of the Beall mitral value prosthesis." *Circulation* 45 (Suppl. 1):1-7, 1972.
6. Bjork, V. O., Olin, C., Rodriguez, L.: "Comparative results of aortic valve replacement with different prosthestic heart valves." *J. Cardiovasc. Surg.* 13:268-271, 1972.

6a. Javier, R. P., Hildner, F. J., Berry, W., Greenberg, J. J., Somet, P.: "Systemic embolism and the Beall mitral valve prosthesis." *Ann. Thorac. Surg.* 10:20-26, 1970.

7. Angell, W. W., Shumway, N. E., Kosek, J. C.: "A five-year study of viable aortic valve homografts." *J. Thor. Cardiovasc. Surg.* 64:329-339, 1972.
8. Barratt-Boyes, B., Roche, A., Agnew, T. M., Cole, D., Kerr, A., Monro, J. L., Lowe, J. B., Brandt, P. W.: "Homograft valves." *Med. J. Aust.* 2 (Suppl.) 1:38-44, 1972.
9. Gonzalez-Lavin, L., al-Janabi, N., Ross, D. N.: "Long-term results after aortic valve replacement with preserved aortic homografts." *Ann. Thor. Surg.* 31:594-606, 1972.
10. Ross, D. N.: "Replacement of aortic and mitral valves with a pulmonary autograft." *Lancet* 2:956-958, 1967.
11. Zuhdi, N., Hawley, W., Voehl, V., et al.: "Porcine aortic valves as replacement for human heart valves." *Ann. Thor. Surg.* 17:479-91, 1974.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, in care of the Georgia Heart Association, Broadview Plaza Level C, 2581 Piedmont Road, N.E., Atlanta, Ga. 30324.

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

A unique hospital specializing in treatment of...

ALCOHOLISM
DRUG ADDICTION



In this restful setting away from pressures and free from distractions, the Willingway staff, with understanding and compassion, carries out an intensive program of therapy based on honesty and responsibility. The concepts and methods are original, different and have been highly successful for fifteen years.

John Mooney, Jr., M.D., Director
Dorothy R. Mooney, Associate Director

Willingway Hospital

311 JONES MILL RD., STATESBORO, GA. 30458 TEL. (912) 764-6236

ACCREDITED BY THE J. C. A. H.

Preferred Partnerships inc.



RE: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Mr;

How much income tax are you now paying? We can help you shelter a portion of your present income---plus show you how you can receive Tax-Free income.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that give you a 4-to-1 or better write-off. We have investments in the $5,000-$8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

Voluntary Binding Arbitration of Medical Malpractice Disputes in Georgia—Possibilities for New Legislation

RICHARD H. VINCENT, *Atlanta**

ONE OF THE RESOLUTIONS passed by the MAG House of Delegates in April included an endorsement of the principle of legislation which would allow for voluntary binding arbitration as an alternative to the traditional judicial resolution of malpractice claims. Furthermore, the House of Delegates instructed the MAG Insurance Committee to conduct an in-depth study on a voluntary binding arbitration system for the State of Georgia and to bring specific recommendations to the MAG Board of Directors in September. Legislation of this type has been enacted within the last three years in other states and demonstrates the wide variety of choices which will be available to Georgia legislators wishing to formulate a voluntary binding arbitration system for our state.

Background

Arbitration is the procedure whereby parties agree to submit a disputed matter to an impartial body for determination, and further agree that the determination or award of that body will be final, binding and enforceable in the same manner as a judgment of a court of law. Arbitration is to be distinguished from a "screening procedure" under which either party may reject the conclusions of the impartial body and/or seek redress through the courts, regardless of the determination of the reviewing body.

Most states already have a general arbitration statute which is either a codification of the common law or a more detailed, specific statutory mechanism for arbitrating a dispute. Georgia presently has statutes reflecting both a common law codification and a more detailed statutory mechanism. The codification of the common law[1] simply provides that parties disagreeing as to their rights or liabilities may submit the matter to third persons to decide; and the award made by such arbitrators is binding without an order of court, in the absence of fraud, palpable mistake of law or the casting of lots by the arbitrators. Any number of arbitrators may be selected, and the matter need not be submitted to the arbitrators in writing.

Under Georgia's more elaborate general arbitration statute,[2] the submission of

* Prepared at the request of The Medical Association of Georgia. Mr. Vincent is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C&S National Bank Bldg., 35 Broad Street, Atlanta, Georgia 30303.

the issue must be in writing, only three arbitrators can be selected, the arbitrators take a particular oath, the award must be entered on the minutes of the Superior Court, and it is enforceable as a judgment of the court. General statutory arbitration furthermore provides a detailed and specific procedure for designation of the arbitrators, listing of witnesses, time and place of meetings of arbitrators, etc. Georgia cases have held that a general agreement to submit all future disputes to arbitration is against public policy and does not oust the courts from jurisdiction of the matter; a party may go to court without first submitting the matter to arbitration.[3] A carefully drafted agreement to submit not all, but only certain specific future disputes to arbitration as a condition precedent to seeking redress in the courts will be given effect.[4]

In other states recently, malpractice statutes have modified the general arbitration statutes to be specifically applicable to medical malpractice cases and to include consumer safeguards designed to encourage the use of arbitration for resolving medical malpractice disputes. These consumer safeguards (discussed below) are incorporated to minimize the usual difference in bargaining strength which exists between the medical institution on the one hand and the patient on the other, and thereby to create a situation in which both parties can comfortably submit the matter in dispute to arbitration—with the expectation of receiving an equitable and enforceable result, quickly, informally and inexpensively.[5]

Variations on the Theme

1. **Coverage.** Some statutes specifically list the different care providers who may take advantage of the statute. The general intention, however, is that any party who agrees to submit a matter to arbitration may do so, and it would seem that any attempt to list providers might prove restrictive and fail to achieve the general purpose of encouraging the use of arbitration.

2. **Claimants.** Although arbitration is available to any person, some statutes go the extra step of specifically allowing parents and guardians to enter into arbitration agreements on behalf of children, wards, incompetents or deceased persons.

3. **Future Claims.** Some statutes allow for arbitration agreements only with respect to existing claims, while most others specifically permit arbitration agreements to apply both to existing and future medical malpractice claims.

4. **Relations With Insurance Companies.** Some statutes include a helpful provision that professional liability insurance cannot be withheld from health care providers because they have agreed to arbitrate malpractice claims. In addition, at least one statute requires that all liability insurance contracts written for hospitals in that state require the hospitals to offer binding arbitration agreements to patients.

5. **Voluntary Nature.** Virtually all medical malpractice arbitration statutes provide for the arbitration to be voluntary. One exception is that California allows mandatory arbitration as a provision in a negotiated contract between a health maintenance organization or other prepaid health plan and its subscribers.

6. **Duration of Agreement.** Although some statutes specify a maximum length of time for such agreements, most statutes are silent with respect to the duration of an agreement to arbitrate. This permits hospitals to utilize agreements covering any event occurring during a particular admission, while physician agreements may be based on an ongoing relationship.

7. **Revocation and Voidability.** As a means of encouraging consumer usage of arbitration agreements, some states provide that an agreement to arbitrate can be voided by either party at any time prior to the award; other states permit the arbitration agreement to be voided only by the patient; still other states permit it to be voided only by the patient within a limited period of time.

8. **Notice and Explanation to Consumers.** As a further consumer safeguard, most of the new laws require significant notice provisions to be given to the consumer to the effect that he is agreeing to arbitrate an issue when he signs a form

contract. Some statutes even specify the size of type and color of type which must be utilized in the notice and explanatory provisions.

9. **Arbitration Panels.** Some statutes specify the number of panelists which must be appointed, while others leave this to the agreement of the parties. Some statutes impose qualifications on the panelists (for example, that one be a lawyer, one be a health representative, and one be neither of these nor an insurance company representative). So far as the selection of the arbitrators is concerned, many states permit this to be specified in the arbitration agreement itself; other states establish a roster of panelists usually composed of lawyers, physicians, or hospital administrators selected by the president of the appropriate professional association in the state.

10. **Evidence and Witnesses.** One approach is to appoint a three-person expert advisory panel to investigate and report in writing on the medical facts of the claim. Another approach is to permit the arbitration panel to consider authoritative published works on the specific subject involved in the particular claim, so long as prior written notice is given to all parties. A third approach authorizes the arbitration panel to call a neutral expert on its own motion, affording all parties the right to cross-examine. Some statutes make specific provision for subpoena power both for witnesses and for the production of evidence.

11. **Awards.** Most statutes provide some time period within which the award must be rendered. Some statutes require an opinion in addition to the award itself. One statute authorizes not only a money judgment, but also authorizes the arbitration panel to award hospitalization, medical or rehabilitative procedures, support, or any combination of these.

The great variety evidenced in the medical malpractice arbitration statutes of other states will require considerable review by those who would draft an act for Georgia. On the other hand, such variety makes it possible to tailor an act for Georgia which incorporates the best features of the statutes in other states.

REFERENCES

1. *Ga. Code Ann.*, Ch. 7-1 (1973).
2. *Ga. Code Ann.*, Ch. 7-2 (1973).
3. E.g., *Laurence v. White*, 131 Ga. 840, 63 S.E. 631 (1909).
4. E.g., *Southern Mutual Ins. Co. v. Turnley*, 100 Ga. 296, 27 S.E. 975 (1895); *Sasser & Co. v. Griffin*, 133 Ga. App. 83, 210 S.E. 2d 34 (1974).
5. The balance of this article is a summary of "American Arbitration Association, Statutory Provisions for Binding Arbitration of Medical Malpractice Claims" (1976).

EXHIBITS AT SCIENTIFIC ASSEMBLY

The Planning Committee for the 1977 MAG Scientific Assembly is accepting a limited number of applications for non-commercial scientific exhibit space. The meeting will be held November 17-20 at the Omni International Hotel in Atlanta.

Deadline for receipt of applications is October 1. Application forms may be obtained by writing to **Stephen L. Daniel, MAG, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.**





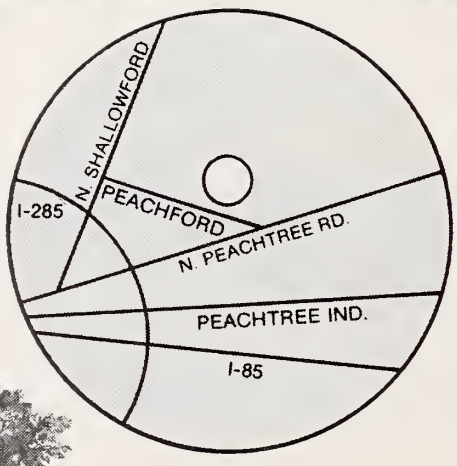








PEACHFORD PERSONNEL PICTURED





PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200

MAG SERVICES INCORPORATED

QUALITY
AND
INEXPENSIVE

PRINTING SERVICES FOR DOCTORS

PRESCRIPTION BLANKS
Standard Size 4¼ x 5½ in Pads of 100

500	1000	2000	4000
5.75	7.95	14.65	26.55

BUSINESS CARDS OR APPOINTMENT CARDS

	1000	2000	4000
White Stock One Side	6.95	12.65	22.95
For Color Stock, Add	1.00	2.00	4.00
For Two Sides	11.85	20.95	39.95

LETTERHEADS

20 LB. WHITE BOND				
SIZE	500	1000	2000	4000
7¼ x 10½ 8½ x 11	11.16	15.70	24.98	42.72
20 LB. RAG CONTENT (25%)				
7¼ x 10½ 8½ x 11	13.90	21.16	35.91	64.75

ENVELOPES
TO MATCH LETTERHEADS

24 LB. WHITE WOVE				
SIZE	500	1000	2000	4000
6¾	12.88	15.96	25.51	47.90
Monarch	13.70	17.59	28.76	54.40
#10	13.77	17.74	29.06	55.00
20 LB. RAG CONTENT				
Monarch	20.23	30.63	54.86	106.60
#10	20.86	33.97	57.43	111.75

WINDOW ENVELOPES
24 LB.

SIZE	500	1000	2000	4000
6¾	13.83	17.84	29.26	55.40
#10	14.85	19.89	33.36	63.60

Composition and type set charges are in addition to quoted prices.

UNIFORM INSURANCE CLAIM FORMS (Approved by AMA)
$18.50/1000 — Single Copies — Pads of 100

SEND ORDERS TO:
MAG SERVICES, INC.
(a service company of the Medical Association of Georgia)
968 PEACHTREE ST., N.E.
ATLANTA, GA. 30309
(404) 873-4136

INTERNIST/FAMILY PRACTITIONER: TIRED OF CITY TURMOIL?

Lake Elsinore, which is located only one hour south of Los Angeles and one hour north of San Diego needs you now. The area offers the best of living conditions in one of the most beautiful areas of California.

Due to population growth, we are now in need of two Internists and one Family Practice Physician. We offer excellent guaranteed income for first year with free office space and household move provided. If you want a busy practice away from city pressures, write with C.V. or call:

LAKEVIEW GENERAL HOSPITAL
Chris DiCicco, Administrator
P.O. Box 489
Lake Elsinore, California 92330
Telephone: (714) 674-1421

Office space ideal for Pediatrician or General Practitioner!

DeKalb Professional Building, 2754 N. Decatur Rd., conveniently located across from DeKalb General Hospital.

This office — 1,050 square feet is divided into a waiting room, business office, lab area, four examining rooms, private office/consultation room, two complete rest rooms, and dark room. Available for immediate occupancy.

For further information contact: Roy T. Summers
DeKalb Professional Building Suite 113
2754 N. Decatur Rd. Decatur, Georgia 30030
Telephone 292-3600



the association
the association
the association

NEW MEMBERS

Albee, Robert B. Jr., MAA—A—ObG
Suite 815, 401 Peachtree St., Atlanta 30308

Appelrouth, Daniel J., MAA—A
960 Johnson Ferry Rd., NE, Atlanta 30342

Castle, Robert F., MAA—A—Pd
Suite 402, 960 Johnson Ferry Rd., NE, Atlanta 30342

Chen, Ching-Tsai, Telfair—A—ObG
Doctors Building, 1107 Parsonage St., McRae 31055

Elliott, Paul M., Wayne—A—FP
111 Colonial Way, Jesup 31545

Freireich, Ronald, Clayton-Fayette—A—C
33 SW Upper Riverdale Rd., Riverdale 30274

Hanks, Jefferson D. Jr., Richmond—A—R
MCG Dept. of Radiology, Augusta 30902

Kim, Christine S., Cobb—A—R
3949 S. Cobb Dr., Smyrna 30081

Levine, Allan N., Cobb—A—Or
3910 Austell Rd., Austell 30001

Michaelides, Kyriakos M., Cobb—A—I
1678 Mulkey Rd., Austell 30001

Nassour, Paul A., W-C-D—A—FP
Tri-County Hospital, Ft. Oglethorpe 30742

Phillips, Robert L., Wayne—A—FP
111 Colonial Way, Jesup 31545

Purser, Alvin D., Wayne—A—FP
P.O. Box 937, Jesup 31545

Raphael, Rafik M., MAA—A—Path
Kennestone Hospital, Marietta 30060

Rees, Klaus O., Cobb—A—C
Suite 314, 1001 Atlanta W. Blvd., Lithia Springs 30057

Rimando, Leonardo F., SE Ga.—A—Su
207 E. Third St., Vidalia 30474

Rockfeld, Robert D., MAA—A—Or
4569-L Northside Parkway, Atlanta 30339

Saxena, Virendra M., SW Ga.—A—FP
P.O. Box 54, Ft. Gaines 31751

Smith, Richard Noel, Cobb—A—TS
2550 Windy Hill Rd., Marietta 30067

Tollison, Joseph W., Richmond—A—FP
MCG Dept. of Family Practice, Augusta 30902

Wike, Charles C., Hall—A—Su
194 Gold St., NE, Gainesville 30501

Wittum, Roger L., Cobb—A—I
3001 S. Cobb Dr., Smyrna 30080

Wu, Chuen-Shiong, W-C-D—A—Pd
1 Thomas Rd., Ft. Oglethorpe 30742

PERSONALS

First District

Gerald E. Caplan, M.D., Savannah, has been named a fellow of the American College of Radiology.

Second District

Moultrie orthopedic surgeon **David Adcock, M.D.,** spoke at a recent meeting of the Georgia Association of Licensed Practical Nurses. His topic was "Spinal Injuries and Some of Their Complications." He used various audio-visual aids to show the nurses the importance of X rays in the planning of treatment and also talked about different types of protheses available to orthopedic patients.

Cancer Society unit volunteers in Moultrie kicked off this year's education campaign recently. **Bill Brown, M.D.,** Colquitt County Memorial Hospital pathologist, was the guest speaker for the occasion. He explained his work in cancer detection and treatment and answered questions about the latest findings in cancer research.

Robert D. Walker, M.D., Albany, was recently made a fellow of the American College of Radiology.

Third District

Orthopedic surgeon **Jack Hughston, M.D.,** head of the Hughston Orthopedic Clinic in Columbus, was named "Physician of the Year" by the Governor's Committee on Employment of the Handicapped. Dr. Hughston helped establish the two Shriners' Crippled Children's Hospitals in Greenville, S.C., and helped develop the Crippled Children's Clinic in Columbus. He has won national acclaim for his work with the handicapped.

Several members of the Board of Regents of the University System of Georgia have initiated a scholarship fund at Georgia Southwestern College, Montezuma, to honor **John H. Robinson III, M.D.,** Americus physician and member of the Board of Regents. The honor was bestowed on Dr. Robinson for his contributions to education. The scholarship fund will be used primarily for freshmen entering the college.

Orthopedic doctors from around the world honored Columbus physician **Jose Serrato, M.D.,** recently by presenting him with a citation from the Pan American Congress of the American Academy for Orthopedics. He was responsible for putting together the first joint meeting of orthopedics from across the Americas. The meeting, which took place in Mexico, was to "promote

DOCTOR, LAWYER
INDIAN CHIEF

Whatever your profession let us assist in making your home, office (or teepee) a perfect reflection of your taste and needs.

River Interiors is a professional interior design firm with exciting ideas plus practical know-how.

Do you want to spruce your space up a bit? Start fresh from scratch? Or want a new look using pieces you already have? River Interiors can do it with distinction and within your budget.

Interior design improvements are very personal. So we will make house calls to discuss your particular needs----- one professional to another. Consultation without obligation.

Call now for an appointment: 434-0828.

River
interior design

Smyrna, Georgia.

INCOME
PROPERTY
INSURANCE

You can reduce your insurance cost and have quality protection. We also offer estate planning, malpractice and personal insurance coverage.

Call:

JOHN LUSK
Insurance Agents, Inc.
Two Northside 75
Atlanta, Ga. 30318
(404) 351-8434

exchange of ideas in the North and South Americas and through scientific interchange upgrade knowledge in the field."

The American College of Radiology has named **John D. Watson Jr., M.D.,** a fellow in the society.

Fourth District

Amir H. Ansari, M.D., director of obstetrics and gynecology at Georgia Baptist Medical Center, participated in the Pan American Conference on Fertility and Sterility held recently in Puerto Rico. He also participated in the 9th World Congress on Fertility and Sterility in Miami and was a guest speaker at the Ft. Lauderdale Obstetrical and Gynecological Society.

Robert E. DeLashmutt, M.D., director of pathology and medical director of Georgia Baptist Medical Center's School of Medical Technology, was recently appointed clinical professor in Georgia State University's College of Allied Health Sciences. Dr. DeLashmutt was also appointed deputy commissioner for the Gulf Region for the College of American Pathologists.

Chief of staff for Georgia Baptist Medical Center, **Edwin C. Evans, M.D.,** has been re-elected to the Board of the American Society of Internal Medicine's Socio-Economic Research and Education Foundation. The foundation was formed in 1960 to encourage research and educational projects related to the practice of medicine.

John Heard, M.D., and **Andy Morley Jr., M.D.,** have been named diplomates of the American Board of Family Practice.

June 5 was "Dr. Henlen and Dr. Ferrol Sams Day" in Fayette County. The county paid tribute to **Helen Sams, M.D.,** and **Ferrol Sams, M.D.,** both of whom have been physicians in the county for over 25 years. Planners of the special day said it was to "pay a very special tribute to two very special people."

Fifth District

Grady S. Clinkscales, M.D., recently attended a combined meeting of Hand Surgeons from Europe, Canada and the United States, held in Vienna. While there, Dr. Clinkscales presented a paper on congenital anomalies in the upper extremity.

Recently honored by admission to fellowship in the American College of Physicians are: **Gordon J. Azar, M.D., Edward Dyckman, M.D., John G. Leonardy, M.D., Arthur J. Merrill Jr., M.D.,** and **Mario J. R. Ravry, M.D.**

Named diplomates of the American Board of Family Practice: **James F. Langford, M.D.,** and **Omer L. Eubands, M.D.**

R. Carter David Jr., M.D., president of the Emory Medical Alumni Association, recently presented Awards of Honor to **Thomas F. Sellers Sr., M.D.,** and **Alton V. Hallum, M.D.,** for their service to Emory Medical School and the community.

Sixth District

William A. Dodd, M.D., Wrightsville, has been awarded active membership in the American Academy of Family Physicians.

LaGrange physician **Hoke Wammock, M.D.,** has been elected president of the Medical College of Georgia's School of Medicine Alumni Association. Also elected: **Harvey Newman, M.D.,** Gainesville, president-

elect; **Calvin Jackson, M.D.,** Manchester, first vice president; **David Wells, M.D.,** Dalton, second vice president, and **Harold S. Engler, M.D.,** Augusta, secretary-treasurer.

Governor George Busbee has reappointed **H. Calvin Jackson, M.D.,** to the State Medical Education Board.

Seventh District

Family Practitioner **Richard Hammonds, M.D.,** Austell, has been appointed by President Carter to the National Health Insurance Issues Committee, a 29-member committee which is chaired by HEW Under Secretary Hale Champion.

New president-elect for the Georgia Academy of Family Physicians is **Steve May, M.D.** of Kennesaw.

A. I. Miller, M.D., and **Bernard Strickman, M.D.,** both of Smyrna, have been honored by medical staff members at Kennestone Hospital. The doctors' names were placed on a plaque commemorating them for service to the hospital and the community.

Donald R. Rooney, M.D., Marietta, has been re-elected to a three-year term on the Board of Chancellors of the American College of Radiology. Dr. Rooney is a clinical assistant professor of radiology at Emory and is on the staff of Kennestone Hospital and Paulding County Memorial Hospital.

David A. Wells, M.D., Dalton, has been appointed to the State Medical Education Board by Governor George Busbee.

Eighth District

Named diplomates of the American Board of Family Practice: **Charles Oliver Barker, M.D.,** Valdosta; **Tommy K. Stapleton, M.D.,** Douglas.

Got a knack for public speaking?
Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at **(404) 876-7535; INWATS (800) 282-0224.**

DEATHS

Edward Bernard Waxler

Edward Bernard Waxler of Waycross died March 28 at the age of 37.

Dr. Waxler received his medical degree from the New York University Medical School. He served his internship and residency at the Kings County Hospital in Brooklyn and took a fellowship in cardiology at Hahnemann Hospital in Philadelphia. He was a fellow of the American College of Cardiology and a fellow of the American College of Physicians.

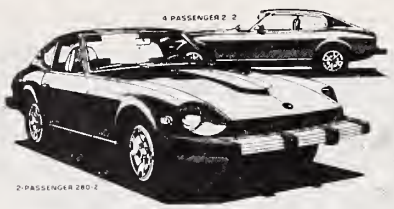
He was also a lieutenant commander in the U.S. Naval Reserve Medical Corps.

Dr. Waxler is survived by his wife, Barbara Cushman Waxler; daughter, Caroline Harkness Waxler; son, Andrew Reed Waxler; his parents; a sister; a brother.

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD.
2 MILES INSIDE I-285
Phone 455-1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND ...
We have the South's best service for the whole Datsun Line!

NOW . . . CME RECORDKEEPING WITH COMPUTER ACCURACY AND CONVENIENCE!

The Physicians Registry brings computer accuracy and convenience to CME (Continuing Medical Education) recordkeeping. It's a complete service—*we* keep track of all your CME credits.

You'll receive everything you need. After participating in a CME activity, just fill in one of the brief, pre-printed cards the Physicians Registry provides and mail it to us.

Every three months, you'll receive a computer-generated summary of your credits. You'll also get annual reports summarizing all credits for the past three years.

Think of the confusion and wasted time you'll save. Of course, your records are completely confidential. And your periodic reports from the Physicians Registry can come in very handy at tax time.

The cost is a modest, *deductible* $50 per year. Over 1500 physicians have already enrolled in The Physicians Registry, and we have successfully recorded over 77,000 hours of CME credit.

You may spend up to $2,000 per year on CME activities. Why not spend $50 to keep your CME records efficiently?

Consider joining The Physicians Registry.

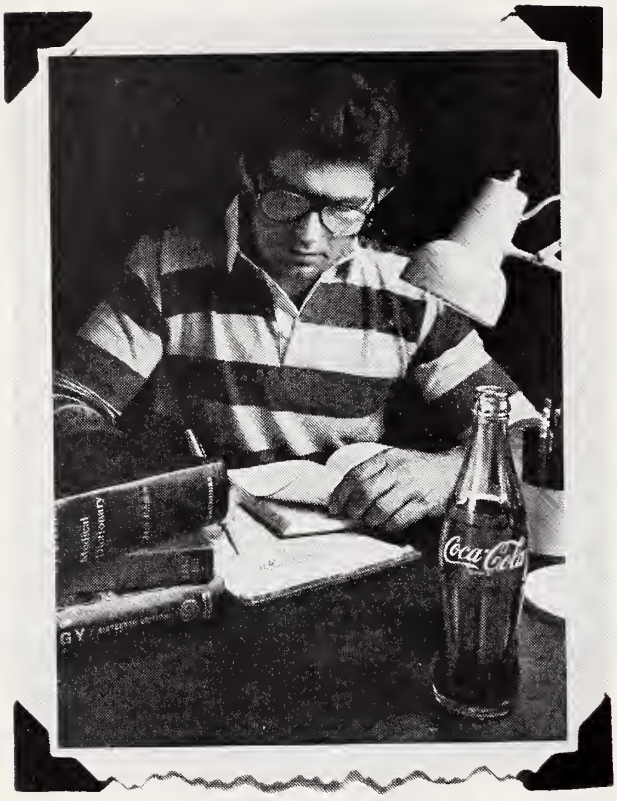
For more information, write:

Richard J. Ladon, Director

THE PHYSICIANS REGISTRY

640 North LaSalle Street, Chicago, Illinois 60610
Or call us collect at (312) 368-1377

Coke adds life to... those special moments.



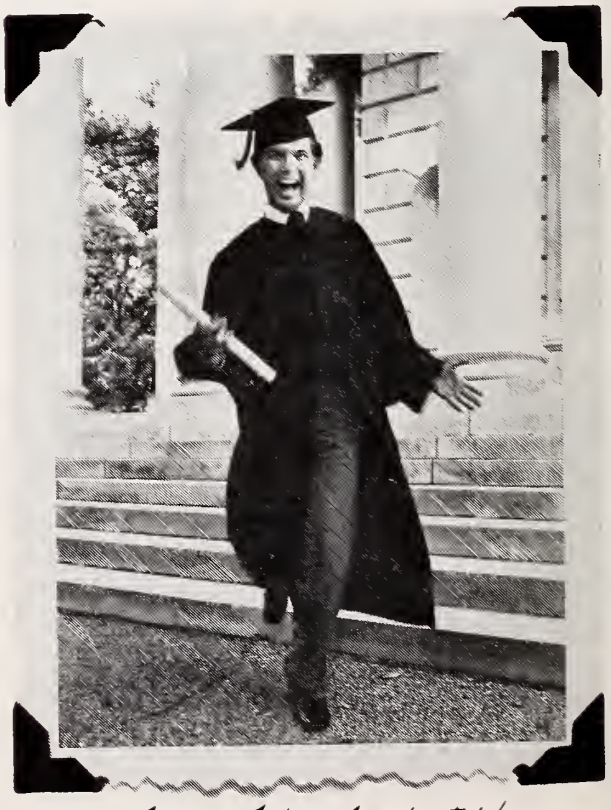
June 2: 2 A.M. Me! Cramming for Inorganic Chemistry finals. Man was I beat!



Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

"Coca-Cola" and "Coke" are registered trade-marks which identify the same product of The Coca-Cola Company.

Classified Advertising

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

ALABAMA: Emergency Physician: Full time, $70,000+ per year, fee for service, group health insurance, malpractice paid, funded continuing education, 305 bed regional medical center plus 350 bed community hospital and 100 bed community hospital with inhouse and outpatient responsibility. New ED facilities within 18 months with interns and resident teaching. Contact: Medical Director, P. O. Box 9639, Marina del Rey, CA 90291, Phone (213) 822-1312.

CONFERENCES FOR MEDICAL PROFESSIONALS. A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialities included. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

GP—WANT MORE Free time? Approaching retirement? I've got an idea! Share practice in perfect location with new, fully-equipped office, including lab and X ray. No in-patient care. Work Thursday, Friday, Saturday, Monday, Tuesday and Wednesday; then be off one week. Nothing to buy. North metro Atlanta location. Please send resume to Box 5-1, c/o the *Journal*.

FAMILY PRACTICE AVAILABLE. Large-volume practice and office building available due to death of mid-forty practitioner in January 1977. Practice fully equipped and located on main thoroughfare to Gatlinburg, Tennessee, in Sevierville, Tennessee. Extremely reasonably priced with excellent terms. Growing multi-specialty medical community, modern expanding hospital and nursing home facility in the foothills of the Great Smoky Mountains, only 40 minutes from Knoxville. Contact by calling collect (615) 453-3821 or (615) 693-0041.

EMERGENCY PHYSICIAN NEEDED. Must relocate to Griffin, Georgia (30 miles south of Atlanta). Work load: 20,000 patients annually. Flexible schedule with weekend work. Salary: guaranteed $22 per hour for minimum of 36 hours per week, with additional pay for weekends. Potential for profit sharing. Position available September 1, 1977; part-time available in August. Contact: Dr. Gail L. Lamb, M.D., 4800 Mumford Rd., Macon, Ga. 31204.

OFFICE TO SUBLET. Leaving practice. Will share office from July 1, 1977 to October 1, 1977, or sublet from October 1, 1977 to October 13, 1978. Office equipment also for sale. Decatur North Professional Building, downtown Decatur, Georgia. Call (404) 377-6459, 9-5, Monday through Friday.

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital. 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Call 262-3580.

INTERESTED IN OTHER STATE MEDICAL JOURNALS? The Journal office has a collection of 1976 state medical journals from all over the country. If you'd like them, or know someone who could put them to good use, contact Sharon Smith at MAG headquarters, 938 Peachtree St., NE, Atlanta, Ga. 30309. Phone: (404) 876-7535 or toll free (in Georgia) 1-800-282-0224.

Got a knack for public speaking?
Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at (404) 876-7535; INWATS (800) 282-0224.

Index to Advertising

Vol. 66 July 1977 No. 7

Walter Ballard Optical Company 560
Brawner Hospital Inc. 514
Bugatti Restaurant 541
Burroughs Wellcome Co. 564
Capital Automobile Company 520
Classified Advertising 587
Coca-Cola Company 586
DeKalb Professional Building 582
Dickey-Mangham Company 569
Dorsey Laboratories 531, 532
Duluth Professional Park 513
Eager and Simpson 520
French Restaurant, The 541
Georgia Army National Guard 538
Georgia Cancer Line 570
Hickman Datsun 585
Hill Crest Hospital 560
Lakeview General Hospital 582
Eli Lilly and Company 518
Lusk, John, Insurance Agency 584
MAGNET Conference 556
MAG Services, Inc. 582
Max' Restaurant 541
Merck Sharp & Dohme 553, 554
Metropolitan Psychiatric Center 516, 517
Mimi's Restaurant 541
Non-Invasive Cardiac Services, Inc. 520
North Carolina Department of Human Resources 569
Omni International Hotel 541
Ortega Pharmaceutical Company, Inc. 575
Peachford Hospital, Inc. 580, 581
Peachtree and Parkwood Hospitals 533
Physicians Registry 585
Potter-Holden & Company 569
Practice Productivity, Inc. 524
Preferred Partnerships, Inc. 576
River Interiors 584
Roche Laboratories 512, 562, 563, 589, 590
Roerig 529
Scott Hudgens Properties 513
Smith, Kline & French 561
Squibb & Sons, Inc. 549, 550, 551, 552
Terrace Garden Inn 557
United States Navy 524
The Upjohn Company 530
Valley Psychiatric Hospital 574
Waronker, William, Silver Investments 560
Weight Watchers of Greater Atlanta 524
Willingway Hospital 575
1977 MAG Scientific Assembly 540

JOURNAL
of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

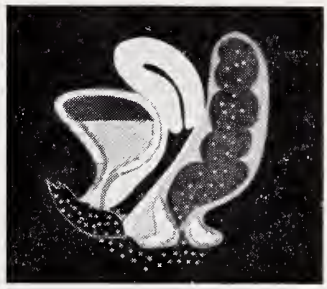
MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

Her next attack of cystitis may require

the Bactrim™ 3-system counterattac



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

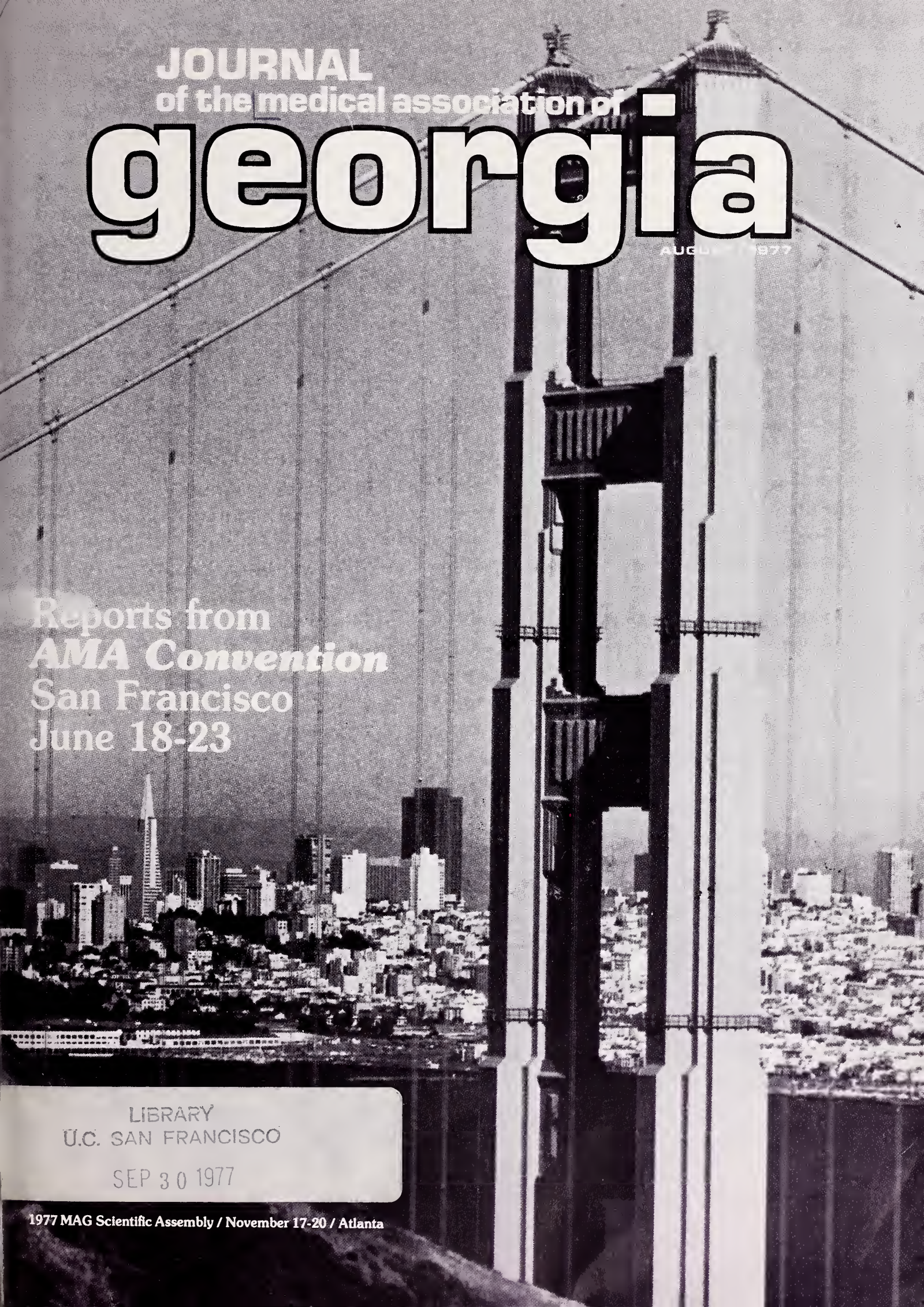
The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introi colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

JOURNAL
of the medical association of
georgia
AUGUST 1977



Reports from *AMA Convention* San Francisco June 18-23

LIBRARY
U.C. SAN FRANCISCO
SEP 30 1977

1977 MAG Scientific Assembly / November 17-20 / Atlanta

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

So near and yet so far away is not a contradiction.



Scott Hudgens Properties

Duluth Professional Park

IN GROWING GWINNETT COUNTY—A BEAUTIFUL OFFICE COMPLEX WITHIN A 1500-ACRE PLANNED UNIT DEVELOPMENT.

So near . . . Joan Glancy Memorial Hospital . . . Atlanta Athletic Club . . . major Northside corridors leading to metropolitan Atlanta . . . a growing community.

And yet so far away . . . from the hustle and bustle of the city. Each Williamsburg designed building has private entrances for staff and doctors . . . plenty of parking . . . plenty of peace and quiet.

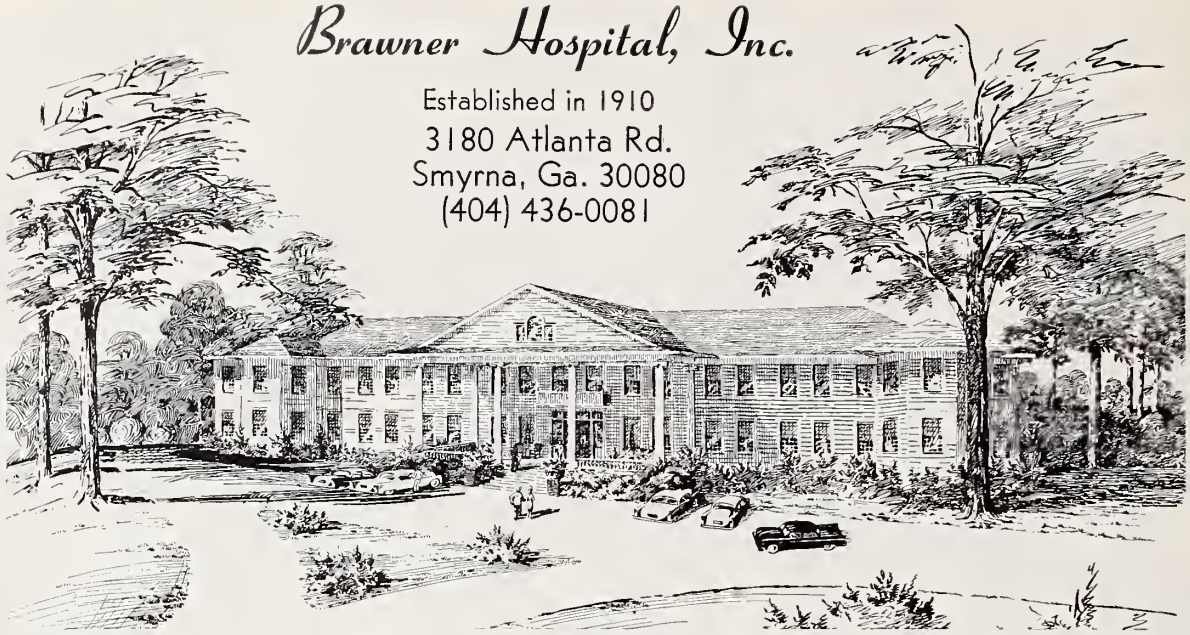
All new buildings . . . all are ground level. Competitive rates and custom-designed interiors make this a superlative opportunity.

Howell Station
ON THE RIVER

Contact
Dan Arnold
P.O. Box 988
Duluth, Ga. 30136
(404) 964-1351

Brawner Hospital, Inc.

Established in 1910
3180 Atlanta Rd.
Smyrna, Ga. 30080
(404) 436-0081



Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 8

EDITOR
Edgar Woody Jr., M.D.
MANAGING EDITOR
Sharon T. Smith
BUSINESS MANAGER
L. B. Storey
ADVERTISING REPRESENTATIVE
Mary Coté
CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta
PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1. Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

616 One Year's Experience of a Regional Neonatal Intensive Care Unit
William P. Kanto Jr., M.D.
Alex F. Robertson III, M.D.
625 Internal Radiation Therapy of Liver Cancer
Edgar D. Grady, M.D.
Thomas R. Nolan, M.D.
A. J. Crumbley, M.D.
A. R. Rosen, M.D.

SPECIAL ARTICLES

599 Prevention and Recognition of Athletic Injuries
Fred L. Allman Jr., M.D.
607 Reports from the AMA Convention, San Francisco, June 18-23, 1977
633 Statement by the AMA on Unnecessary Surgery

EDITORIALS

637 Ahlquist, Basic Research and the Practice of Medicine
A. C. Witham, M.D.
639 Harrison Rogers, Vice Speaker
Edgar Woody, Jr., M.D.
639 Thanks to Everyone
Harrison L. Rogers Jr., M.D.

FEATURES

640 I've Told This Before/ A Cruel Man
J. G. McDaniel, M.D.
642 President's Letter/ Congratulations to Harrison Rogers
Robert E. Perry Jr., M.D.
644 Legal Page/Antitrust and the Health Industry—Straws in the Wind
Richard H. Vincent
654 Heart Page/Current Concepts: Exercise and Coronary Disease
John D. Cantwell, M.D.

THE ASSOCIATION

663 New Members
663 Personals
664 Deaths

NEWS

636 Scientific Assembly to Feature Workshop on Asthma
657 The *Journal* 50 Years Ago
659 Medical Meeting Calendar
667 Speakers Bureau

THE COVER

The Golden Gate Bridge and Marin County headlands overlook San Francisco, Site of the 1977 AMA Convention held June 18-23. For reports on what took place there, see pages 607, 639 and 642. Cover photo and photo on page 607 from the San Francisco Convention & Visitors Bureau. Cover design by Bob Hamill, Atlanta.

When it's pinworms, treat the family



Brief Summary of Prescribing Information

Actions: Pyrvinium pamoate appears to exert its anthelmintic effect by preventing the parasite from using exogenous carbohydrates. The parasite's endogenous reserves are depleted, and it dies. Povan is not appreciably absorbed from the gastrointestinal tract.

Indication: Povan is indicated for the treatment of enterobiasis.

Warnings: No animal or human reproduction studies have been performed. Therefore, the use of this drug during pregnancy requires that the potential benefits be weighed against its possible hazards to the mother and fetus.

Precautions: To forestall undue concern and help avoid accidental staining, patients and parents should be advised of the staining properties of Povan. Care should be exercised not to spill the suspension because it will stain most materials. Tablets should be swallowed whole to avoid staining of teeth. Parents and patients should be informed that pyrvinium pamoate will color the stool a bright red. This is not harmful to the patient. If emesis occurs, the vomitus will probably be colored red and will stain most materials.

Adverse Reactions: Nausea, vomiting, cramping, diarrhea, and hypersensitivity reactions (photosensitization and other allergic reactions) have been reported. The gastrointestinal reactions occur more often in older children and adults who have received large doses. Emesis is more frequently seen with Povan Suspension than with Povan Filmseals.

How Supplied: Each Povan Filmseal® contains pyrvinium pamoate equivalent to 50 mg pyrvinium, supplied in bottles of 50 (NDC 0710-0747-50; NSN 6505-00-134-1966). Povan Suspension, a pleasant-tasting, strawberry-flavored preparation containing pyrvinium pamoate equivalent to 10 mg pyrvinium per milliliter, is supplied in 2-oz bottles (NDC 0071-1254-31; NSN 6505-00-890-1093).

RC/RD PD-JA-1699-2-P (8-76)

Parke, Davis & Company
Detroit, Michigan 48232

Povan® (pyrvinium pamoate)

- over 17 years of proved clinical effectiveness and safety
- no measurable absorption from the GI tract—minimal systemic side effects
- one dose—one time—that's all that's usually required
- two dosage forms: Tablets and Suspension—suitable for the entire family

Povan—there's a form for every member of the family.

PARKE-DAVIS

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

Serving the General Insurance needs of the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.
Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT ®

DO YOU HAVE A

SCHOLAR—ATHLETE—ARTIST

or an average Joe or Jane? If so, we have a program for you at

WOODWARD ACADEMY

A $1,700,000, BUILDING PROGRAM IS IN PROGRESS TO BE COMPLETED IN THE 1977 SCHOOL YEAR:

- $1,000,000 Fine Arts Center
- Middle School
- New Library Addition
- 7 New Tennis Courts
- New Administration Building

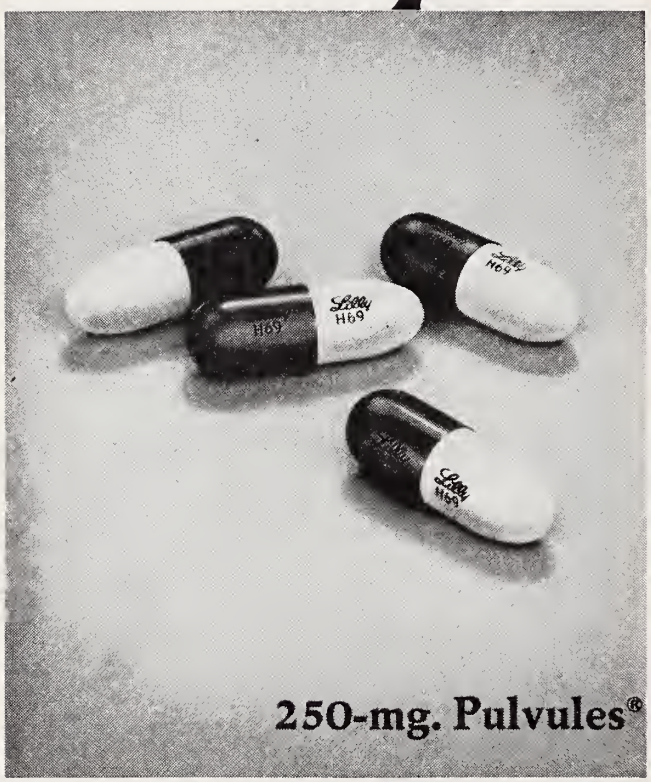
For Boys and Girls
Boarders and Day Students

For information on all schools and programs, write or call:

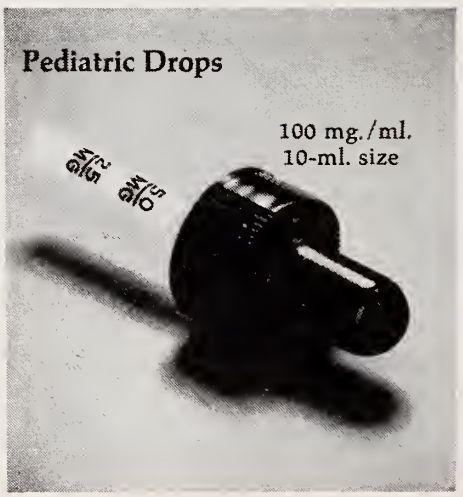
Admissions Director
P.O. Box 87190-L
College Park, Georgia 30337
(404) 761-8881

Woodward Academy Administers a Non-Discriminatory Admissions Policy

easy to take







Keflex®
cephalexin

Lilly

500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

JOURNAL
of the medical association of
georgia

Prevention and Recognition of Athletic Injuries

FRED L. ALLMAN JR., M.D., *Atlanta**

PARTICIPATION IN ATHLETICS is a privilege involving both responsibilities and rights. The athlete's responsibilities are to play fair, keep in training, and to conduct himself with credit to his sport and his school. In turn, he has a right to optimal protection against injury and this may be assured through good conditioning and technical instruction, proper regulations and conditions of play, and adequate health supervision.

With the number of people involved in all types of recreation and sports activities, and the high injury rate even in non-contact sports, there is an ever-increasing need to make these activities as safe as possible. There are a number of factors that must be considered if sports and recreational activities are to be kept safe and if proper treatment is to be administered.

What Is Sports Medicine?

Sports medicine is the study of problems and the application of solutions to the problems as they relate to the physiological, psychological, and pathological nature of the athlete. It involves sports, but is not limited to organized athletics; it involves medicine, but is not limited to injuries. Sports medicine concerns itself with the health implications of the organism and physical activity; thus, sports medicine spans the gamut from the highly trained athlete who is endowed with sufficient skill and a physique to participate in modern competitive athletics with great intensity and diversity, to the neophyte "little-leaguer" who often lacks skill and physique and who might play in the vacant lot without any supervision.

Sports medicine involves sports but is not limited to organized athletics; it involves medicine but is not limited to injuries.

The assumption to which sports medicine subscribes requires the interpretation and refinement that only competent research activity can offer. It also requires application to the individual the appropriate decisions that only a competent practitioner can make. Sports medicine thus has the task of linking research and practice.

The prospective which is sports medicine requires a team. Various professions, each with its own responsibilities, cooperate with mutual understanding and respect with physicians, dentists, educators, athletic trainers, biological scientists, and behavioral scientists comprising most of the sports medicine professional reservoir. Conceivably any professional person could apply his competencies to some component of sports medicine.

Sports medicine differs from other forms of medi-

* The Sports Medicine Clinic, P.C., 615 Peachtree St., NE, Atlanta, Georgia 30308.

cine in a number of ways. The attainment and maintenance of high levels of physical readiness required of top athletes produces significant effects on the working of the human organism. This high level of physical fitness or physical readiness often so alters the physiological make-up of the individual that his response to injury or disease actually differs from that of the non-athlete. The same process by which physical readiness is achieved may give rise to pathological conditions of one form or another which may fall outside the scope of "normal" clinical practice.

Practicing physicians often are so concerned with the grossly sub-normal that the super-normal, only slightly disabled by usual standards, is apt to receive scant attention. Yet, to the athlete himself, even a slight disability might mean the difference between playing or sitting on the bench, between winning and losing. A sprained wrist would hardly incapacitate the banker, but would be certain to alter the performance of a pole vaulter. Similarly, a businessman might be able to transact business nearly as usual with a strained hamstring muscle, while the hurdler, running back or flanker would have his performance altered appreciably. Also, it should be remembered that in addition to his office, the doctor who treats athletic injuries must include observation of the athlete in the gymnasium or on the playing field as an integral part of the evaluation. It is there that function can best be determined, and unless they have the complete return of function, performance is likely to be altered.

The doctor who treats athletic injuries must include observation of the athlete in the gymnasium or on the playing field as an integral part of the evaluation.

Another very important difference between sports medicine and other forms of medicine exists because injuries which are sustained during athletic participation are usually produced by circumstances inherent in respective athletic performance and they are therefore characterized by exposure to recurrent identical trauma, making re-injury likely. Therefore, in conditioning for athletic participation and in rehabilitation following injury, the ultimate goal must be complete restoration of function to the greatest possible degree and in the shortest possible time.

Prevention of Athletic Injuries

There are a number of important factors that relate to the prevention of athletic injuries. Ten of the most important factors are: a good pre-participation evaluation; equitable competition; conditioning; equipment; playing facilities; coaching technique; rules and regulations; prompt care following an injury; complete rehabilitation, and evaluation after return to play following an injury.

A good pre-participation evaluation. A well-conceived, well-executed pre-participation or pre-season evaluation can help to make sports safer. The purpose of a complete physical evaluation is fivefold: to determine the general state of health of the athlete; to disclose any existing defects; to uncover conditions that might pre-dispose to injury; to institute treatment that will bring the individual to an optimum level, and to classify the individual according to his own qualifications.

The evaluation must be thorough, with special consideration being given to rating the candidate on his level of maturation and physical development as well as his level of physical readiness. Slocum (1959) has pointed out that the objective of such examinations is not only to determine which players meet all physical qualifications and thus may participate with safety, but also to determine whether an individual may play safely in spite of definite recognized defects that appear detrimental on the screening examination but on thorough study can be classified as not harmful.

Equitable competition. Equitable competition relates not only to the skill level of the participating athlete, but also to the physical fitness and maturity levels of the individual. It also relates to the competition between schools being equitable. In other words, participation between an A school with limited enrollment should not be allowed with an AAA school with a much larger enrollment and many more candidates for the athletic team. Also, the newer schools with less experienced athletes should not compete with older, more experienced athletes and athletic teams, even though the size of the schools may be quite large.

Proper conditioning. The role of conditioning in obtaining top performance in athletes cannot be emphasized too much, yet too few physicians, coaches, and trainers fully understand the important components of a conditioning program and thereby fail to utilize them effectively. Also, it should be remembered that conditioning is a primary factor in prevention of injury. Bilik (1941) has stated that the primary objective of intensive conditioning is to "put the body with extreme and exceptional care under the influence of agents which promote its health and strength in order to enable it to meet extreme and exceptional demands upon it. Training aims to condition the muscles, the heart, the lungs, the joints, the nervous system, the mind and the

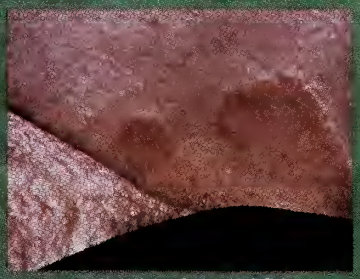
When Griseofulvin is indicated...



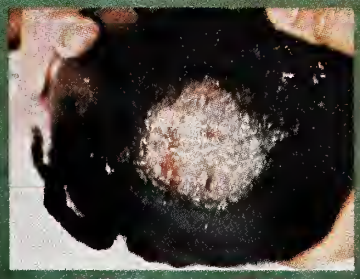
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize)
Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

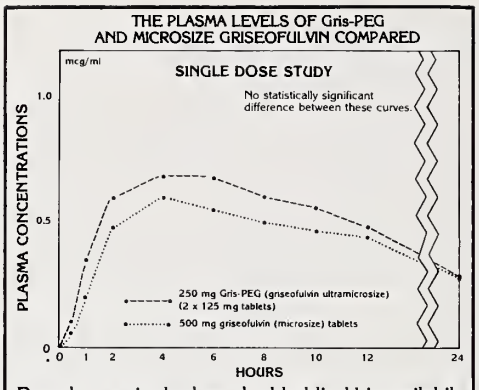
†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



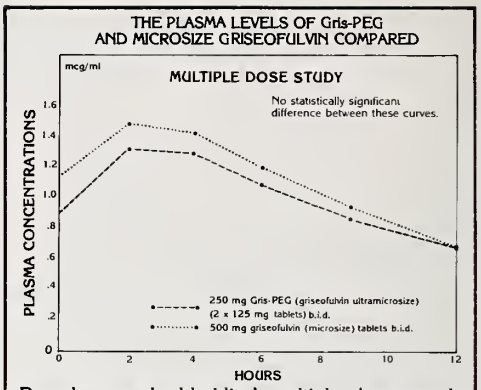
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

Gris-PEG®
(griseofulvin ultramicrosize) Tablets 125 mg
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION
Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION
Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS
Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS
This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS
Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS
Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS
When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION
Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED
Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

Dorsey LABORATORIES
Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

whole body, every tissue and every cell, to function at maximum possible efficiency and to stand up under the most gruelling stress and strain."

The primary purpose of conditioning, then, is to promote physical fitness and sports fitness. Physical fitness, while important for every individual, is essential for the athlete. Physical fitness helps the athlete to enjoy physical activity, it sustains learning skill, it enhances excellence, and it decreases the chance of injury. Also, physical fitness helps to speed recovery following injury.

Proper equipment. Every sports activity presents an opportunity for injury. Some injuries are not entirely preventable, since they arise from the nature of the actions performed in the sport, even when it is conducted under the most ideal conditions and with careful and prudent supervision. However, many injuries which occur during athletic participation may be prevented or at least minimized by the proper use of protective equipment.

Today's application of new materials, increased knowledge of what equipment is desirable, and advanced engineering principles have contributed overwhelmingly to the vast improvements made in the development of protective devices. However, the principle that was true many years ago still holds today: unless the protective equipment is properly fitted to the individual and worn correctly, it will not offer significant protection. The practice of passing used equipment down the line from player to player over a period of years is potentially hazardous and should be eliminated. The athlete has to be made to know that the coach expects him to wear the equipment in a proper fashion, and periodic checks should be made by the coach or trainer to make certain that the equipment is being worn properly.

Proper playing facility. The North Carolina study that was recently completed found that a very significant reduction in knee injuries could be effected simply by cleaning off and improving the surface of the playing field. The removal of obstructions along the periphery of the playing field also made participation less hazardous.

Coaching technique. Each coach must instruct his players concerning the knowledge of how to play and must assure the condition of being physically fit to play. The coach must be capable and fair and must have the ability to instill within each child the desire to win and yet teach that victory sometimes can be gained even in defeat. The coach should have a basic knowledge concerning the mechanism of injury to athletes and how to avoid certain hazardous procedures and also should be familiar with first-aid measures which can be taken immediately in case an emergency arises.

Rules and regulations. Each and every athlete should be taught to play not just within the rules themselves, but within the spirit of the rules. Any suggested rules legislation must meet the following standards before inactment as a rule change: 1) is it safe for those who play the game; 2) is it a rule that all schools, large and small, can use; 3) is it a coachable rule and one that can be administered by the game officials; 4) does it keep the desired balance between the offense and defense; 5) last, but not least, is it a rule that makes the game enjoyable and interesting to the fans who by their attendance pay the way for the program. Each athlete should realize that the rule has been made for his benefit; it has not been made as a means of punishment, but only for his protection.

Prompt care of an injury once it has occurred. When an athlete is injured, the coach should make certain that he receives the necessary treatment. This might be a simple observation of the fact that only a bandage needs to be placed over a blister. Maybe the new shoe needs to be changed or broken in more slowly. It may mean that the athlete needs to have surgery. Whatever the injury might be, prompt and proper care should be initiated immediately to enable full recovery in the shortest possible time.

Complete rehabilitation following an injury. The athlete who is injured must be ready to return to activity before the coach allows him back. The coach should not try to second-guess medical authority who has determined that the athlete is not yet ready to return to activity. The athlete may be very important to the game, but unless he is physically ready, he will not be as effective to the team as the number-two man. The athlete who is allowed to return to the game prematurely is much more likely to sustain another injury.

Evaluation of the athlete after he has returned to play following an injury. The coach and the physician as well as the trainer (when there is one available) must continue to observe the athlete after he is allowed to return to participation. They must determine if the athlete is performing up to par, at normal speed, and with his usual vigor or if, in fact, he acts like there is still a disability present.

Recognition of Athletic Injuries

There are more than 20,000 physicians in the United States engaged in the care of school athletes, many of them without pay or compensation other than the love of a job well done. Most of these physicians treat athletes because they like athletics and because they feel that athletics offers benefits to those who participate; however, there are large numbers of athletes, particularly the younger athletes,

who are not cared for by a qualified team physician or an individual who has devoted special time and effort to preparing himself to treat athletes. The physician who treats the occasional athlete has just as much responsibility in the recognition of athletic injuries as does the specialist who sees them daily, for he must recognize the need for further, more definitive treatment in case this is something that he himself cannot properly care for.

The correct recognition of athletic injuries demands a thorough history and physical examination. The physician must know the circumstances surrounding the injury. When did the injury occur? Where did it occur? What was the mechanism? Was there contact involved? Was there immediate disability or did the signs and symptoms develop at some later time? Has there been progression of symptoms or is the individual getting better? Has there been any treatment instituted? Has there been a previous injury to the same area?

Once the physician has it completely clear in his mind as to how the injury occurred and the circumstances that have taken place since the injury, then a thorough physical evaluation is necessary. In case of injury to the extremity, the normal extremity should be compared with the injured extremity and observed for deformity, swelling, or any other abnormality that might be present. Next, the area should be felt and areas of tenderness localized. This should be done carefully and without producing any more pain than necessary. Lastly, the area should be manipulated to determine whether or not there is abnormal motion, grating or crepitation. Since this often is painful, it should be performed last. From the standpoint of the musculo-skeletal system, one of the most important early determinations should be the presence or absence of abnormal motion. Each ligament about a joint should be checked for tenderness and then for laxity, and the extent of laxity should be determined. It should be remembered that if there is any abnormal motion present, then something must have been completely torn, unless there was pre-existing abnormal movement. Any joint that has abnormal motion must be protected and evaluated so that the appropriate treatment can be instituted at the earliest possible time. If the abnormal motion is present in the knee, then this often indicates that surgery will be necessary. This is true to some degree in injuries about the shoulder and ankle as well; however, laxity in the shoulder and ankle does not present the same anatomical difficulty as does the knee, and because of this, the knee much more frequently requires surgery than does the shoulder or ankle. Even the small joints of the finger need to be checked for laxity. Often the collateral ligament might be torn at the interphalangeal joint, and if this is allowed to go untreated, deformity and swelling will persist and disability may ultimately be the result.

Dr. Don H. O'Donoghue has listed six principles as being foremost in the treatment of athletic injuries. These are: 1) the goal must be complete recovery; 2) it is important to avoid mere expedience; 3) the best treatment must be selected rather than the most convenient; 4) treatment must be definitive; 5) treatment must be prompt; 6) the physician must believe in competitive athletics, for if the physician does not, he will not have the complete interest of his patient and the patient will not have faith in the physician.

The athlete should be allowed to return to athletics as soon as his recovery is complete. Once this feeling becomes known to athletes and coaches, they will no longer be hesitant about consulting the physician when injury occurs.

In conclusion, the physician must play the lead role in any preventive program to reduce the incidence and severity of athletic injuries. He also plays the primary role in the recognition and treatment of athletic injuries, for only he is capable of deciding the playability of the athlete after he sustains an injury.



Lake Arrowhead. A guaranteed 8.6% annual return. And a great resort, too!

Take for example our million dollar Country Club that overlooks the sparkling 500 acre lake. Stretching out behind the Country Club is a magnificent hillside championship golf course, second to none in this entire area. We also have a beautiful Swin and Tennis Club with tournament courts and a huge pool, all waiting for your family.

Where does the guaranteed 8.6% annual return come in? It's made possible by our exciting and revolutionary marketing plan. If you purchase a Lake Arrowhead homesite under this plan, you will receive a guaranteed 8.6% annual return on the annuity premium upon maturity, which **will pay you back the original purchase price you paid for your beautiful Lake Arrowhead homesite and annuity.**

For complete information, call **266-1002** Visit our Atlanta office at 3400 Peachtree Road in the lobby of the Lenox Towers, or use this handy coupon. Remember, this is a limited offer.

Please send me free and complete information about Lake Arrowhead's new marketing concept under which I am guaranteed 8.6% annual return on the annuity.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

AMNG

LAKE ARROWHEAD

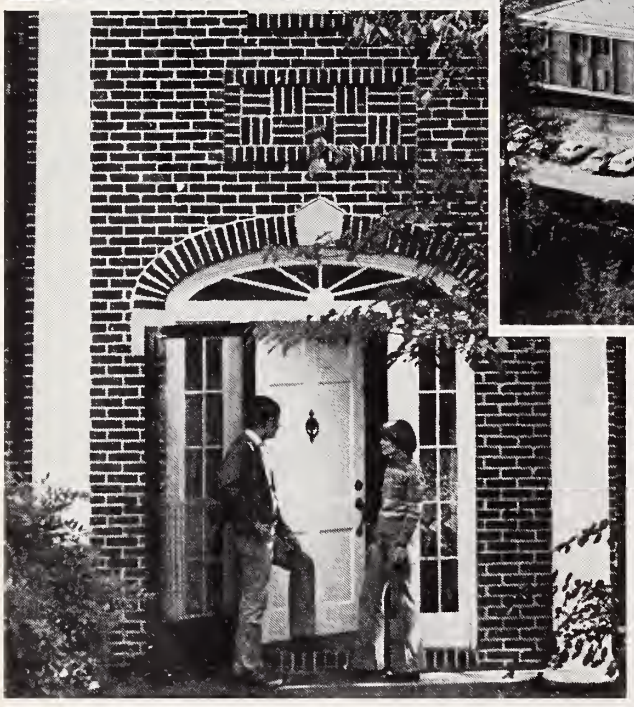
...where a sound opportunity awaits you.

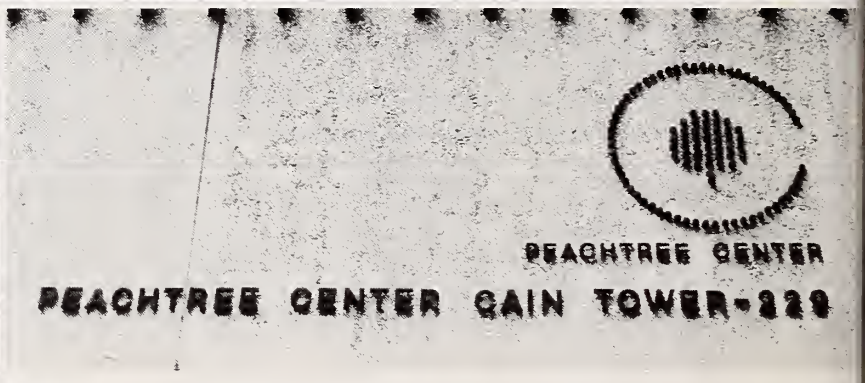
Obtain the HUD property report from developer and read it before signing anything. HUD neither approves the merits of the offering nor the value, if any, of the property.
This ad does not constitute an offer to sell in any state where such an offer is prohibited.











PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD

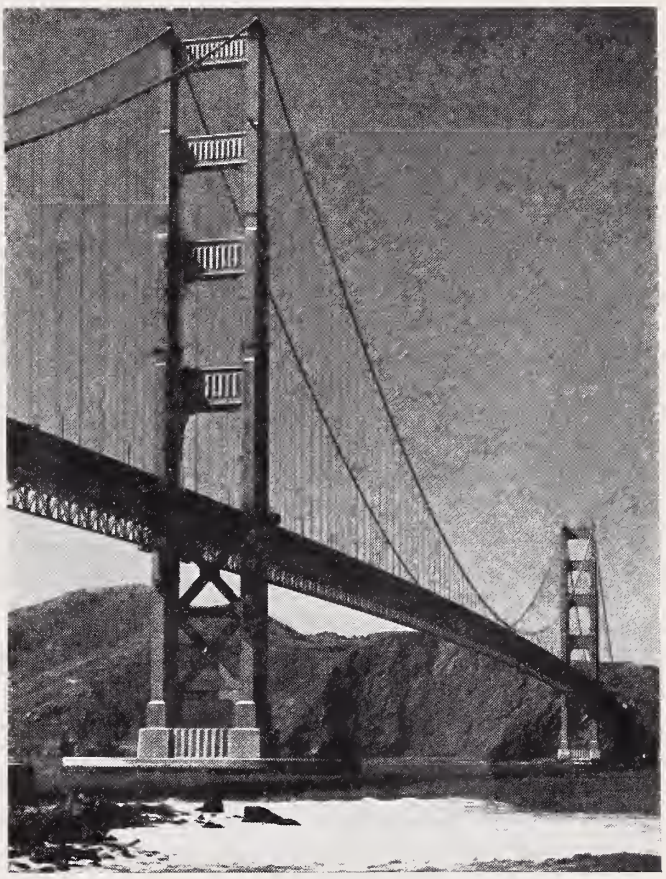
Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Reports from the AMA Convention San Francisco, June 18-23, 1977

MAG members and their families turned out in large number to attend the AMA Convention this year. Several of them have written down their observations of events of special interest to Georgia physicians . . .



REFERENCE COMMITTEE A
Earnest C. Atkins, M.D.

Fifteen reports and thirty-two resolutions were discussed, debated and reported by this Reference Committee.

The House of Delegates rejected reports F and E that recommended setting up nationwide Peer Review as a commercial service.

Reports A and substitute resolution 28 were adopted and did not change the AMA's position on PSRO; however, in resolution 46, criteria for alternate PSRO's were adopted.

Report D as **amended by our Georgia delegation** was referred to the Board of Trustees. The amendment was, "The American Medical Association continue to seek elimination of the 'economic index.' The AMA should pursue a policy whereby a prompt revision of individual profiles can be made which is not tied to a previous base in any medically underserved area within a state."

Substitute resolution 101 was adopted and referred to the Board of Trustees for action: "Resolved, that the officers and staff of the AMA investigate all possible avenues, including legislative action, which might prevent the release of Medicare-Medicaid reimbursement lists."

Resolution 1, to compare cost of government subsidized medical services to those provided by private physicians, was adopted.

Georgia resolution 68 on the freedom of choice and direct billing was not adopted, but we plan to clarify this resolution and resubmit it in December at the Chicago meeting.

Report I of the Board of Trustees on Relative Value Studies was adopted in lieu of Resolutions 11, 77 and 80 and was thus: "Board of Trustees Report I recommends efforts to enact national legislation to confirm the profession's authority to develop and use Relative Value Studies. Some speakers warned against pending legislation which would allow development of RVS at the request of HEW, but reference committee A believes the Board statement makes clear its intent that the authority to develop and use these studies should rest with the profession."

Resolutions 19 and 27 recommended that child health care by the schools not be fragmented.

Report I of the Council on Medical Service in lieu of Resolution 13 and presented guidelines and suggestions to medical societies and individuals contemplating purchase of expensive diagnostic or

therapeutic equipment.

Resolution 67: Physicians' assistants: This resolution asks that the AMA oppose all governmental efforts to use and promote PA's in lieu of rather than under the supervision of physicians. The action requested by this resolution has already been implemented by the association, as outlined in Council on Medical Service Report L (A-77).

REFERENCE COMMITTEE B
Robert E. Perry Jr., M.D.
Carson B. Burgstiner, M.D.

Reference Committee B had to do with the legislative activity of the AMA and, as might be expected, the main thrust of reports and resolutions were on National Health Insurance and the sponsorship by the AMA of House Bill 1818 and Senate Bill 218 dealing with comprehensive health care insurance. Most of the resolutions were in opposition to this position, and at the Reference Committee hearing, much philosophy was presented, both pro and con, to the position of the AMA in this program. The Reference Committee recommended that the policy and position taken by the Board of Trustees and affirmed by the delegates at the Philadelphia meeting be continued, and when the Reference Committee report was presented to the House of Delegates, there was more discussion of this position.

During the final hours of the Annual Session, the House reaffirmed its support of the AMA-developed national health insurance bill, "The Comprehensive Health Insurance Act of 1977." A stipulation was added, however, that disavowal of national health insurance as envisioned in the British system continue to be the preamble of any statements by the AMA and that the use of the term "comprehensive health insurance" be substituted in reference to the legislative package offered by the AMA.

During the final hours, the House reaffirmed its support of the AMA-developed national health insurance bill

The subject of two Board of Trustees reports and eight resolutions received considerable discussion during the meeting. Perhaps the most vociferous and thought-provoking argument against the bill was presented by Dr. F. Michael Smith of the Louisiana delegation. *(Editor's note: space limitations prevent reprinting his testimony here; however, anyone who would like a copy can receive one by sending a self-addressed-stamped envelope to The Journal, 938 Peachtree St., NE, Atlanta, Ga. 30309.)*

There are now 41 sponsors in the House for the AMA bill, and its present status referred to the House Committee on Ways and Means and Interstate and Foreign Commerce and the Senate Committee on Finance and Human Resources. The AMA position is that its bill is gaining support, has a good chance of passing Congress and will preserve the present basic insurance and private practice system as we know it. The AMA feels that the more onerous parts of the bill can be amended while in the hopper. The bill minimizes federal intervention, thereby encouraging the responsiveness and innovation in the private sector.

Dr. Palmer pointed out that National Health Insurance cannot improve health care or control costs and that 85 percent of the people are satisfied with the present system and oppose an NHI program paid by increased taxation.

National Health Planning: One report of the Board of Trustees and four resolutions involved national health planning. The AMA delegates adopted a resolution calling on the AMA to monitor HEW monographs, which relate to 16 different clinical areas and serve as technical assistance documents to be used by health planning agencies in conducting their reviews. Another resolution supported efforts to repeal the National Health Planning and Resources Development Act of 1974. Another resolution would have AMA take the lead in developing a program of guidance, advice and strategy for physicians and medical societies involved in health planning activities.

The delegates adopted the Board of Trustees legislative liaison report, which urges AMA officers, staff, counsel and committee chairmen to work with officers and staff representatives of state medical societies to bolster federal legislative relationships through "key men" legislative programs, exchange information and get input from individuals and groups of physicians on critical national health issues.

Adopted a resolution calling for a separate cabinet level Department of Health for all federal activities in health care.

Opposed hospital cost ceiling proposed by President Carter.

Called for legislation to give physicians the same billing options under Medicaid they have under Medicare.

Another item that the Reference Committee considered had to do with the position of the AMA on resident and house staff being included under the National Labor Relations Board (HR-2222).

Needless to say, there were resolutions calling for

the repeal of Public Law 94-641 (Health Plan and Resources Development Act). In view of the legal action being taken by the AMA along with the Medical Society of North Carolina, these resolutions were referred to the Board of Trustees for study.

With regard to the Hospital Cost Containment Act, strong opposition was expressed in resolutions 53 and 109, and the Reference Committee combined these with one resolve: that the AMA continue to voice its opposition to HR-6575 and S-1391 as introduced in the 95th Congress. This resolution was adopted by the House of Delegates.

Resolutions having to do with the Health Professional Educational Assistance Act of 1976 (Public Law 94-484) were referred to the Board of Trustees for further study.

Reference Committee B covered seven Board of Trustees reports and 32 resolutions. Arguments and compromise raged all day and into the night. The highlight of the House of Delegates actions on the Reference Committee reports occurred when Speaker Tom Nesbitt interrupted proceedings to announce that Dr. Harrison Rogers of Georgia was elected Vice Speaker of the House of Delegates of the American Medical Association. Harrison enjoys respect and support of the AMA, and we here at home need to get behind him 100 percent and work hard for a better, more informed AMA and keep organized medicine where it belongs—with dedicated physicians and out of the hands of governmental bureaucrats.

REFERENCE COMMITTEE C
Fleming L. Jolly, M.D.

Reference Committee C, which dealt primarily with medical education, was represented by Dr. Hilt Hammett and myself. Approval of residency program guidelines were given to General Surgery, Urology, Neurological Surgery, Thoracic Surgery, and Preventive Medicine.

Concerns in residency programs were considered with "monitoring" proposed by the Council on Medical Education for "shared schedule residencies" and "special requirements" by special boards without prior announcement. The foreign medical graduate received no particular relief, but the unconstitutionality of requiring citizenship to procure a license was documented.

Privileges for the physician in the hospital should be based on assessment of performance rather than any lack in continuing medical education. The state medical organization should approve any organization before AMA gives accrediting CME (except medical schools).

REFERENCE COMMITTEE D
Charles D. Hollis Jr., M.D.

Policy regarding hospital-physician relationships was re-stated and clarified by a report from the Board of Trustees with minimal modification by the Reference Committee. Physicians may enter into whatever financial or contractual arrangements with hospital that are agreed to be mutually satisfactory. Contracts made between hospitals and physicians should be reviewed and approved by the medical staff of the hospitals.

When improved technology allows reduction in the cost of services or procedures, this reduction in

A resolution was adopted by Reference Committee D that could have a significant effect on small hospitals

cost is passed on to the Medicare payors under the Medicare law. Reimbursement must be made on a reasonable cost basis. The AMA emphasized that self-pay and privately insured patients also should not be required to pay more than the actual cost to the institution.

Physicians having contractural arrangements with hospitals should be members of the hospital staff with full responsibilities for medical staff functions. They should serve on committees, participate in continuing education activities, and assist in training of allied health personnel without additional compensation, in the some way that other members of the staff provide these services.

Hospital-associated physicians are entitled to compensation based on time required for their services. However, "percentage arrangements that are unrelated to the amount of the time expended or to the skill, education, and professional expertise of the physicians, and which result in disporportionately excessive earnings should be avoided."

The House of Delegates agreed that when physicians' offices are located in hospital-owned buildings, the rent should be determined on a fixed-fee basis and that the medical staff of the hospital should establish a liaison committee with the hospital governing board to discuss policies for operating the office space.

Upon request of the Section Council on Family and General Practice, the House agreed that clinical departments of family practice should be established in hospitals where the number of family practitioners is large enough and where this is appropriate. These departments should then be comparable to any other

specialty department of the medical staff. The AMA Board of Trustees was instructed to inform the Joint Commission on Accrediation of Hospitals of this policy in an effort to eliminate situations in some hospitals where family practitioners feel there has been arbitrary or discriminatory restriction of privileges for which they are trained and qualified.

A resolution by the Oregon delegation was adopted that could have significant effect on small hospitals, especially those with low levels of occupancy. It was pointed out that in many areas there is a surplus of acute hospital beds with a critical shortage of skilled nursing home facilities. For this reason, the following resolutions were adopted: "The AMA should support current legislative and regulatory proposals that will permit acute short-term hospitals to reclassify a patient's status to that of skilled nursing upon a physician's advice and instruction, thereby permitting patients to remain in short-term hospitals (where a surplus of hospital beds and a shortage of skilled nursing home facilities exist) at skilled nursing levels of reimbursement." In this way the patient would be allowed to remain in the same room simply by redesignating his status for payment purposes, so that care would be continued at a reasonable institutional level for the patient's problem.

The subject of Laetrile was turned over to the Board of Trustees for further study

Oregon also proposed, and the House agreed, that federal hospitals should be subjected to the same certificate of need requirements as are mandated for community and private hospitals.

Other significant matters discussed by Reference Committee D were referred either to the Board of Trustees or to the appropriate council for further study and consideration again at the next meeting.

REFERENCE COMMITTEE E
F. William Dowda, M.D.

The activities of Reference Committee E were numerous; however, the three most important issues were:

1) Laetrile. Although everyone testifying in the committee and speaking on the floor of the House was convinced of the uselessness of Laetrile as a treatment of cancer, there was considerable disagreement as to the technique required to diffuse the situation and prevent patient exploitation. The whole matter was referred to the Board of Trustees for further study and development of an appropriate position to be taken by the House of Delegates.

2) Blood Bank. The Reference Committee and the House supported the position that there should be cooperation between the Red Cross Blood Bank Division and the American Association of Blood Banks in order that credits established in one section of the country could be transferred to another part and that blood collection drives could be a mutually cooperative affair.

3) Pornography on TV. The Reference Committee heard testimony supporting a strong stand against TV pornography; however, they elected to pursue a course that was less than vigorous. Illinois and Georgia pointed out that our campaign against TV violence was already being effective and that this was the expression of a need *and* an already effective program. The House voted to sustain our position and take a strong stand against TV pornography.

REPORT OF REFERENCE COMMITTEE F
F. G. Eldridge, M.D.

1. The current fiscal condition of the AMA is sound with a favorable variance of $3,369,000 below the budget for the first five months of the 1977 fiscal year.

2. Dues structure is adequate and no changes are contemplated until reserves reach satisfactory level. Dues for regular members remains at $250 annually.

3. The Board of Trustees proposes selection of future convention sites be the responsibility of the Board of Trustees. Suggestions were submitted that Chicago be the site of June meetings, but that December meetings be held in areas of more favorable weather, such as Phoenix, Atlantic City or similar areas.

The Board proposes to continue use of resources to support the scientific program that is a part of the AMA annual convention.

4. The Board of Trustees proposed that "contracts" and/or agreements with state and local medical societies for "direct" billing be mutually satisfactory to all parties. Such agreements would enhance the federation concept.

5. The Council on Long Range Planning and Development recommended direct representation of the specialty societies in the House of Delegates to strengthen and improve unity among physicians.

REFERENCE COMMITTEE H
W. W. Moore, M.D.

Reference Committee H dealt with the following subjects:

(1) *Report J of the Board of Trustees* summarized the activities of AMA concerning professional liability insurance, developments in tort reform legislation and medical risk management and reported on the activities of AMACO—now providing reinsurance for four of the 15 physician-owned insurance companies. AMACO's aim is to provide 10-20% of reinsurance for the physician-owned companies, the remainder being largely supplied by Lloyds of London. A more detailed report of AMACO's activities was requested to be made at the C-77 meeting. AMA has compiled *State Legislation Report, Vol. 5, No. 1, April, 1977*—detailing legislation and related court decisions of 1975-76, and this is available from AMA's Department of Legislation.

(2) The thrust of the *Board of Trustees Report L* was to recognize the diversity of protective methods used by hospitals and physicians and to encourage that this should be an independent activity of each. The Board encourages: a. the avoidance of situations which might lead to an "adversary" status; b. adequacy of protection for each, and c. development of an effective risk management program.

(3) *Report H of the Board of Trustees* affirmed the intention of support for the Idaho Medical Association in their legal actions which seek validation of their legislative reform program, including limitation of liability for physicians and hospitals. The legislation has been pronounced constitutional "if a medical malpractice insurance crisis indeed existed" at the time of passage. Trial to determine this point is about to take place. The Idaho Medical Association wants more clearly defined and active support. "Vigorous" support was voted by the H of D.

(4) *Report M of the Board of Trustees* recommended that a Section of Medical Administration *not* be established, and this was upheld by the Reference Committee and the House, primarily because of difficulties defining the sources of representation and organizational problems. Most physicians involved in these areas are felt to have alternate avenues of representation in AMA.

(5) A recommendation that increased efforts be made toward communication between AMA and its members and non-members was accompanied by a fiscal note that $625,000 would be required annually for mailing *AMA News* to all U.S. physicians. The House voted to have the Board of Trustees study and report to C-77.

(6) A resolution that AMA recommend banning of all advertising of smoking materials was felt to be impractical and was rejected by the Reference Committee and the House.

(7) Much testimony was given regarding dealing with the problem of the "hired gun"/"circuit riding" professional expert witness. Legal counsel from several states recommended that legislative and administrative definition of qualification would provide a better avenue of control than would any disciplinary program which might be easily misconstrued as attempting to limit the availability of witnesses and testimony. A system of court appointed recognized panels of experts testifying for the court rather than the plaintiff or defendent was recognized, approved and encouraged for those states not using this system.

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

Charles Emory Bohler, M.D., P.C.

Adopted: Addition to Chapter IX of the Bylaws which describes the autonomy of the State Medical Associations.

"The participation of a state medical association in the House of Delegates is voluntary. Policy actions of the Association do not in themselves bind a state medical association or subject it to any obligation that it does not voluntarily assume."

Filed: Interim report of Council on Constitution and Bylaws concerning progress in decimalization of American Medical Association bylaws.

There was extensive testimony on Report B of the Council on Long Range Planning and Development that deals with the question of a full-time American Medical Association President.

The Reference Committee was convinced that the office of the President of American Medical Association must relate strongly and directly to the membership. They also perceived that the role of the

Reference Committee H heard testimony regarding "hired gun professional expert witnesses"

President needs to be given some further consideration. Also, the title of the chief executive officer of the Association needs to be upgraded since he will inevitably be the most clearly identifiable spokesman for the American Medical Association year in and year out.

The matter was referred to the Board of Trustees for further consideration with a proviso that the wishes of the House to elect the American Medical Association President be retained.

Resolution 104, providing for a mechanism for referendum in the Bylaws, was not adopted. Reason-

ing was that issues should be fully discussed in open forums such as Reference Committees or on the floor of the American Medical Association House of Delegates.

AUXILIARY REPORT

Mrs. Russell E. Andrews Jr./President of AMAG

Bedecked with my badge, briefcase in hand, thinking of the busy schedule ahead, I stepped into the elevator to go to the first meeting of the Convention. A gentleman joined me on the elevator ride, smiled as he read my name badge and asked "What does the Auxiliary do at these meetings?" Thinking perhaps others wonder what it is "all about," I have written a short synopsis of some of the speakers we were privileged to hear.

Dr. Tom Haggai, minister and radio personality, stressed "Let's get together! Friendship we must hold to tightly. We always talk about it, but don't do anything about it. Yet, we are not a cold-hearted people. The Minister of Commerce from Denmark asked what was the most unusual characteristic of the people of the United States—the response was generosity of the American People. But our problem is there is so much money can do, yet there are limitations on what it can and cannot do. Even though we are generous in giving, our very giving seems to come back to haunt us. One of the most difficult lessons we have to learn is it takes far more wisdom on the part of the giver to give with discretion than it does on the part of the recepient who receives with appreciation. There is a way of help, and that way must be in a way that the dignity of the recipient is not only preserved, but enhanced. One solution is to help the people become more tomorrow than they were today. All we have to do to build the type of responsive government we need and the type of society to survive a certain number of years, is for us to project in our organizational life that which we need personally."

William F. Buckley Jr., founder, editor-in-chief, and president of *National Review,* presented "some of the problems of freedom." In talking about some of the aspects of freedom, three propositions were selected. The first is that in America, the freedom to deceive is a fact over result. In our age, the freedom of expression has brought on a virtual immunity over many who deceive. But in a society where there is the freedom to criticize, the politician would probably not get away with it except for the indulgence of the only class of citizens professionally trained to isolate the shoot-um-up bang-bang from down-to-earth society. We should all meditate more seriously than we have done. The on-going civil consequence of the extraordinary unity of the abstinence of collectivism form the more critical opinion. Proposition two resolves that the use of humanitarian critiques should be regulated. After a lecture, some college students asked if it was not wrong to make a profit out of human misery. The context of the question was a discussion of socialized medicine. The difference in working for the government is that the salary usually outruns the expenses he incurs, thus he can support his family. The residual difference is, of course, fewer varieties of medical services to choose from, even as we are stuck with a sinful foreign policy. Proposition three: we are, as a society, in danger of losing sight of the case for human freedom and in particular, of the irrelevance of the free market place to give us freedom. I submit the critics of the American society, if they are truly concerned about the survival of the individual, they should focus on those oddments of flaw. One survey result showed the people thought it wrong for the state to tell the writer how to write and to tell the doctor what to study. It is wrong, it was always wrong, and will forever be wrong."

The Auxiliary was challenged to play a leadership role in assuring that all children are vaccinated

Albert B. Sabin, M.D., developer of the orally administered attenuated polio virus vaccine, told the group "in spite of H.E.W.'s and C.D.C.'s report concerning apathy of vaccine usage, there is no direct proof of apathy, but a failure to reach certain groups. The problem of measles immunization is more prevalent than polio today. The information concerning measles vaccine needs to be made available to all groups. There were more than one million cases of German measles last year, and more than four million cases of chicken pox. Japanese researchers are testing a vaccine for this disease which is so far working successfully. Statistics show more illness is from influenza and upper respiratory virus. Recommendations for possible action by the AMA: (1) AMA urge the Congress to enact as quickly as possible legislation that will remove the specter of lawsuits against manufacturer's and administrators of vaccines whether or not they can pay for it; (2) urge the 11 states which have not yet enacted laws requiring certain immunizations as a condition of school application to do so. Make specific recommendations to all 51 states on how to implement these laws; (3) Establishment by AMA its own ongoing commission of immunizations to consider at whenever indicated national needs and policies as a means of more effectively cooperating with the

National Immunization Commission that will probably soon be established; (4) AMA recommend state and county medical societies establish their own ongoing immunization committee to deal with special problems at state and local levels; (5) AMA ask HEW to determine whether the division of its Center for Disease Control in Atlanta needs better operating procedures and leadership. Need to be more responsible in giving out information to physicians, health officers, and the general public; (6) To meet the immediate measles problem, it would be most helpful if the county medical societies would take the leadership in organizing, this summer, local volunteer teams to give the vaccine to all school children from kindergarten to high school; (7) Regarding the ongoing problem of chicken pox—believe immediate plans need to be implemented for determining whether the excellent preliminary results reported from Japan for the vaccine developed there are reproducible and if they are take necessary steps to bring it here; (8) Regarding influenza and respiratory infections, determine if there is justification in continuing annual use of influenza vaccine. AMA committee on immunization consider the requirement for the practical strategy based on killed virus vaccine."

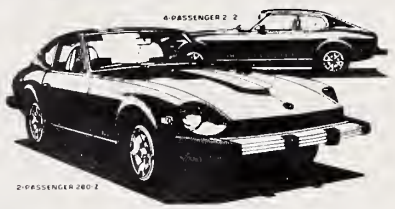
Richard E. Palmer, M.D., president of the AMA, responded to Dr. Sabin's requests. "The AMA has films featuring germs in animated form. All major television stations have been contacted and are enthusiastic about showing these films. The important thing is the props give the television actor the opportunity to talk about immunization and sell the youngsters themselves on the need for immunization. The AMA wants to take the hopscotch theme out of the cellar and use the recognition gained on television so that playgrounds across the country will suddenly sport new, fancy hopscotch courts featuring the different diseases in the blocks. They will be put there by volunteers, using stencils and spray cans of bright paint. Spot announcements will be made on radio stations and information kits will be sent to major American newspapers and magazines. How does all this get done? How do the school yards across the country get painted? How are the television stations convinced of the need for an immunization campaign? What volunteer will be seen on television? We hope it will be the Auxiliary doing all of these things. Kits will be prepared and distributed in late August. We think Auxilians will find this campaign a worthwhile endeavor and it will have a real impact on the level of immunization in our country."

Hopefully, this has given you a glance at some of our activities, and you will agree—yes, there is an auxiliary!

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD.
2 MILES INSIDE I 285
Phone 455-1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND ...
We have the South's best service for the whole Datsun Line!

NOW . . . CME RECORDKEEPING WITH COMPUTER ACCURACY AND CONVENIENCE!

The Physicians Registry brings computer accuracy and convenience to CME (Continuing Medical Education) recordkeeping. It's a complete service—*we* keep track of all your CME credits.

You'll receive everything you need. After participating in a CME activity, just fill in one of the brief, pre-printed cards the Physicians Registry provides and mail it to us.

Every three months, you'll receive a computer-generated summary of your credits. You'll also get annual reports summarizing all credits for the past three years.

Think of the confusion and wasted time you'll save. Of course, your records are completely confidential. And your periodic reports from the Physicians Registry can come in very handy at tax time.

The cost is a modest, *deductible* $50 per year. Over 1500 physicians have already enrolled in The Physicians Registry, and we have successfully recorded over 77,000 hours of CME credit.

You may spend up to $2,000 per year on CME activities. Why not spend $50 to keep your CME records efficiently?

Consider joining The Physicians Registry.

For more information, write:

Richard J. Ladon, Director

THE PHYSICIANS REGISTRY

640 North LaSalle Street, Chicago, Illinois 60610
Or call us collect at (312) 368-1377

- *Scientific programs in 16 specialties: Allergy and Immunology; Chest Disease; Emergency Medicine; Gastroenterology; Internal Medicine; Neurology; Neurosurgery; Nuclear Medicine; Ophthalmology; Pathology; Pediatrics; Plastic Surgery; Public Health; Psychiatry; Radiology; Surgery*
- *Interdisciplinary program on Asthma*
- *Educational Exhibits*

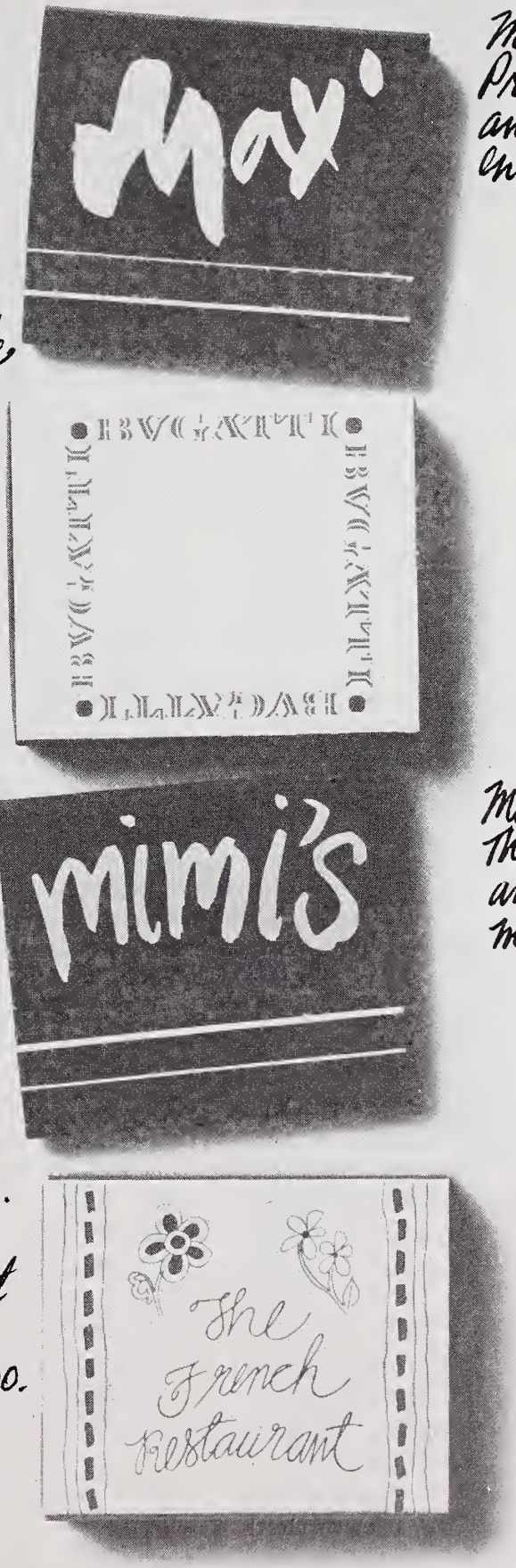
a pleasurable experience in continuing medical education

1977 MAG SCIENTIFIC ASSEMBLY

- *AMA Category 1 credit for all programs*
- *Luncheon and plenary session with a nationally-known guest speaker*
- *Alumni Night*

Omni International Hotel
downtown Atlanta
November 17-20, 1977

For details and registration information, write: 1977 Scientific Assembly, 938 Peachtree St., Atlanta, Ga. 30309, or call MAG, 404/876-7535 (toll free 1-800-282-0224 for long distance calls originating in Georgia).



Mix at Max'.
Prime beef, fresh seafood and late night live entertainment. 522-4442.

The most delightfully delicate dishes this side of the Appian Way. A fine Northern Italian restaurant and Club Bar. 659-0000.

Meet me at Mimi's.
The place to eat, drink and mix if the spirit moves you. 688-5900.

Superb, authentic Gallic cuisine in a garden-like setting. A Holiday Award-winning restaurant with a spirited French Bar. 659-0000.

Omni for all.

You'll find four of Atlanta's favorite restaurants all in one place.
Omni International, Techwood and Marietta Streets, downtown.

Preliminary evidence suggests that these programs in Georgia have been successful in reducing the state's neonatal mortality.

One Year's Experience of a Regional Neonatal Intensive Care Unit

WILLIAM P. KANTO JR., M.D. *and*
ALEX F. ROBERTSON III, M.D, *Atlanta**

ATTEMPTS TO LOWER neonatal mortality in this country have included the development of neonatal intensive care units with the responsibility of providing intensive care for all neonates born within a designated geographical area. This concept has been employed in Arizona and Wisconsin with impressive results.[1,2]

A major reason for the reduction in neonatal mortality has been the decrease in the mortality rate of low-birth-weight infants, associated with the improved care available in intensive care centers. Since every hospital does not have the capability of developing these complex care facilities, regional programs have been developed to extend the service to every hospital.

A plan for the development of a regional program for neonatal care for the state of Georgia was published in 1973.[2] At that time there were three neonatal intensive care centers—Augusta, Atlanta, and Columbus. Two more, Macon and Savannah, have since developed. This report reviews the experience of the center at Augusta during a single year of operation.

Results

There were 464 admissions to the Neonatal Intensive Care Unit of Talmadge Hospital (NICU) during 1975, and 326 (70%) of the neonates survived. Inborn admissions were 130 (28% of total admissions) neonates of whom 93 (72%) survived. Outborn admissions totaled 334 (72% of total admissions) and 223 (70%) survived. The outborn admissions were delivered in 51 community hospitals in Georgia and South Carolina prior to transfer to the NICU.

Table I presents the survival rate in relation to birth weight. The survival rate of all infants increased as birth weight increased, as has been previously reported.[8] When the survival rates of inborn and outborn admissions were compared, there were differences in three birth weight categories. Of the infants below 1001 gm, 54% of the outborn infants survived, compared to only 29% of the inborn infants. The difference is probably secondary to the selection by the referring physician of only those infants for transport whom they felt were "salvageable." The survival of 47% of all admissions with birth weight less than 1001 gm is better than recent reports and would suggest that continued aggressive treatment is justified.[1]

Of the infants weighing 1501-2000 gm, 83% of the inborn infants survived, compared to 63% of the outborn infants. This may represent the beneficial effect of immediate availability of intensive care from the moment of birth. There is a high incidence of the Respiratory Distress Syndrome within this birth weight group and evidence is accumulating that the provision of intensive respiratory support early in the infant's course may reduce the mortality associated with this disorder.[4,9]

Of the infants weighing over 2500 gm, 90% of the inborn infants survived compared to 79% of the outborn infants. This probably reflects the increased severity of disease in the transported group which required their transfer. Infants of birth weight greater than 2500 gms were only transferred when severe illness was present, hence, the lower survival rate.

Survival improved with increasing gestational age

* Department of Pediatrics, Emory University School of Medicine, 69 Butler St., S.E., Atlanta, Ga. 30303.

as has been noted by others (Table II).[8] There were differences in survival between inborn and outborn admissions but these gestational ages correspond to the birth weight groups in which differences have previously been noted and the above reasons apply.

Table III presents the discharge diagnoses of infants. The complexity of neonatal disease results in many neonates receiving more than one diagnosis, therefore, the number of diagnoses listed in Table III exceeds the number of patients admitted. The eight most common diagnoses are listed. The diagnosis of prematurity is omitted from this table. There were 37 (11%) outborn patients and 41 (32%) inborn patients whose primary diagnosis was prematurity. We omitted this diagnosis since we were trying to indicate the types of diseases that an NICU must be prepared and equipped to handle. The major diagnoses are Respiratory Distress Syndrome, other forms of respiratory distress, hyperbilirubinemia, congenital heart disease, birth asphyxia, seizures, sepsis, and multiple anomalies.

There is a close similarity between inborn and outborn admission in the discharge diagnoses (Table III). However, there is a larger percentage of outborn patients with the diagnosis of congenital heart disease (19% vs 3%). This is a reflection of Talmadge Hospital's role as one of two centers in the state offering diagnosis and surgical correction for these infants.

Table IV presents the 6 most common procedures performed on the infants. The two groups are similar with the exception of cardiac catheterization. It is obvious from this table that a tertiary center must be able to perform and maintain umbilical vessel catheters, mechanical ventilation, and continuous distending pressure. In addition the capability for cardiac catheterization and surgery as well as other forms of neonatal surgery, particularly gastrointestinal surgery must be available.

Discussion

Preliminary evidence suggests that the development of neonatal regional programs in Georgia have been successful in reducing the state's neonatal mortality. In 1970 the neonatal death rate in Georgia was 15.5 deaths per 1000 live births. In 1975 this rate was 12.4, a decrease of 20%.[5] Further improvement should occur with complete development of this program into a statewide system.

During the development of NICU's and Neonatal Regional Programs there was skepticism that these efforts would result in improvement of neonatal statistics. There was an air of fatalism associated with the birth of premature infants, asphyxiated infants, and infants with congenital malformations. However, the technology and professional expertise has developed which, when combined with the proper logistical support, has resulted in dramatic improvement in neonatal survival.[12]

Data from other centers support the concept that active, appropriate intensive care will result in improvement of neonatal survival. The experience of our NICU has been similar, since in 1975 almost 70% of infants with a birth weight between 1 and 2 kgm admitted to the NICU survived. It is now clear that the success enjoyed in other parts of the country in improvement in neonatal survival can be duplicated in Georgia.

There has been concern that the improvement in survival of stressed neonates will be accompanied by an increase in the salvage of severely damaged infants. This appeared to be a legitimate concern in light of published studies of handicapped neonates in the 1950's.[7, 8] More recent studies of infants who have received the benefit of modern intensive care indicate that the *intact* survival of graduates from neonatal intensive care units will approach 85%.[11] Preliminary studies of infants from our NICU indicate that greater than 85% of the infants have developmental quotients of 80 or greater. An air of optimism now prevails concerning the outcome of infants cared for in these facilities.[3]

The development of operation of intensive care centers is a complex and expensive task. The cost of equipment for one neonatal intensive care position approaches $20,000. The complexity of care required by these infants necessitates a staffing pattern which allows a nurse to care for no more than 2 patients and provides continuous in-house physician coverage.

The types of procedures required by infants in intensive care further highlights the complexity of these patients. Personnel in the intensive care units must have the necessary expertise to be able to provide this range of service. In addition, they must be supplied with the required equipment. The type of equpiment includes mechanical ventilators, infusion pumps, cardiorespiratory monitors, blood pressure monitors, and isolettes or radiant-warmed open beds. Obviously the capability to properly operate and maintain this equipment is also required.

Since all hospitals do not have the ability to develop a neonatal intensive care unit it is a reasonable alternative to have individual hospitals develop these units and serve a defined region. In order to implement this plan a system of organized transportation must be available to transfer infants from the hospital of birth to the regional center. Such a system of transport must be equipped so that the infant can be transported in safety. Since the same type of illnesses will be present in the infants who are transported as will be treated in an intensive care unit, the transport system must be able to provide the same monitoring and procedures on a temporary

TABLE I

SURVIVAL BY BIRTH WEIGHT OF INFANTS ADMITTED TO THE NICU, 1975

Birth Weight (gm)	All Admissions No.	%	S	%	Outborn No.	%	S	%	Inborn No.	%	S	%
<1001	75	16	35	47	54	16	29	54	21	16	6	29
1001-1500	73	16	42	58	52	16	31	60	21	16	11	52
1501-2000	75	16	53	71	46	14	29	63	29	22	24	83
2001-2500	62	13	50	81	51	15	41	80	11	8	9	82
>2500	179	39	146	82	131	39	103	79	48	37	43	90
Total	464		326	70	334		233	70	130		93	72

S—number of patients who survived.

TABLE II

SURVIVAL BY GESTATIONAL AGE OF INFANTS ADMITTED TO THE NICU, 1975

Gestational Age (wks)	Total Admission No.	%	S	%	Outborn Admission No.	%	S	%	Inborn Admission No.	%	S	%
<29	49	11	15	31	32	10	11	34	17	13	4	24
29-30	31	7	13	42	22	7	10	45	9	7	3	33
31-32	42	9	29	69	33	10	22	67	9	7	7	77
33-34	67	14	46	69	48	14	30	63	19	15	16	84
35-36	66	14	50	76	50	15	39	78	16	12	11	69
37-38	59	13	34	92	39	12	36	92	20	15	18	90
>38	150	32	119	79	110	33	85	77	39	30	34	85
Total	464		326	70	334		233	70	130		93	72

S—number of patients who survived.

TABLE III

DISCHARGE DIAGNOSIS OF NICU ADMISSIONS, 1975

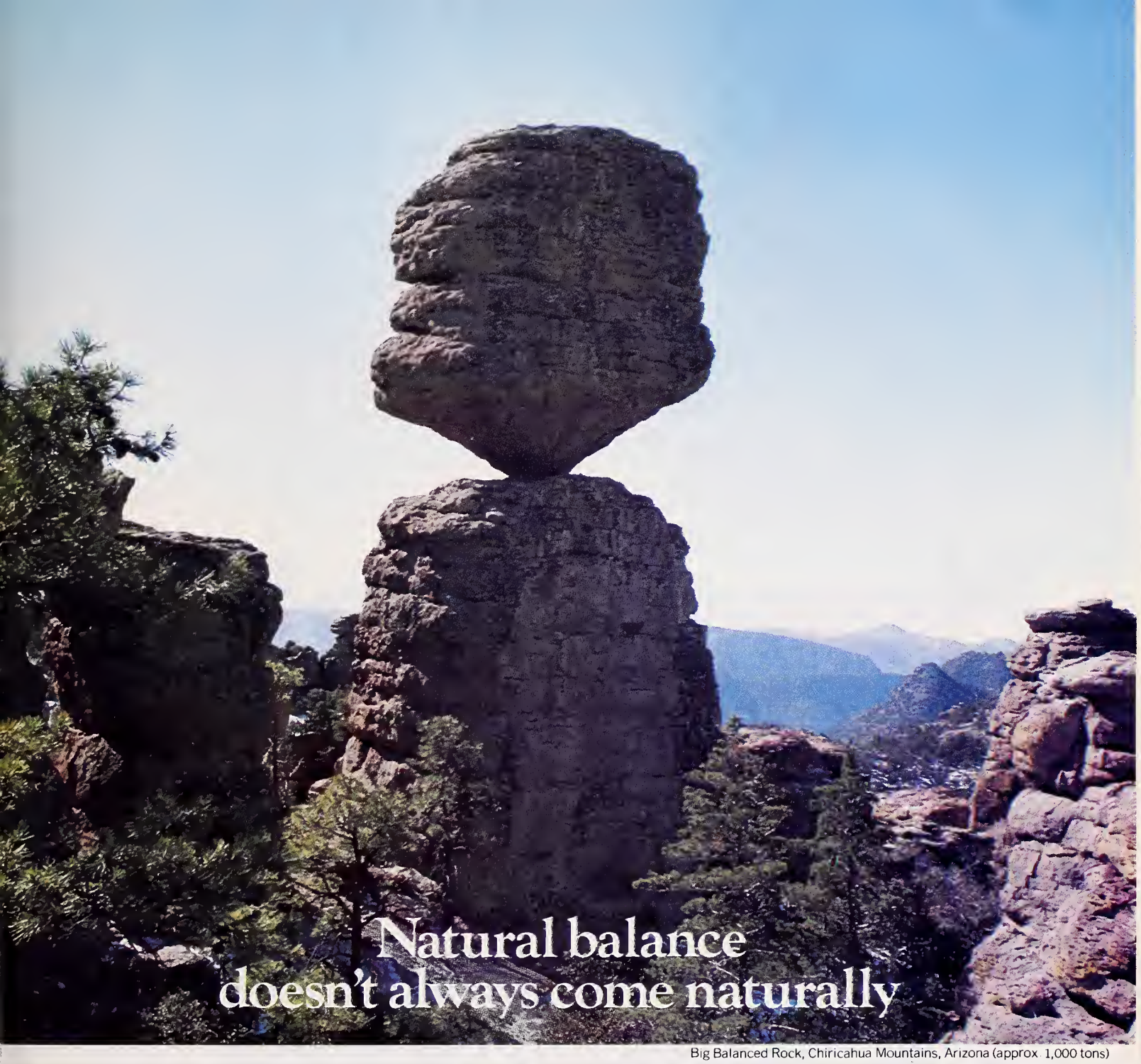
Diagnosis	All Admissions	%	Outborn	%	Inborn	%	S
1. Respiratory distress syndrome	146	31	114	34	32	25	77
2. Respiratory distress, other	101	22	77	23	24	18	71
3. Hyperbilirubinemia	98	21	76	23	22	17	88
4. Congenital heart disease	68	15	64	19	4	3	42
5. Birth asphyxia	38	8	22	7	16	12	20
6. Seizures	38	8	29	9	9	7	22
7. Sepsis	37	8	30	9	7	5	24
8. Multiple anomalies	25	5	23	7	2	2	14

Respiratory distress, other, includes transient tachypnea of the inborn, meconium aspiration, intrauterine pneumonia.
S—number of survivors of all admissions with the specific diagnosis.

basis as is required in the unit.[6] This transport system must be available on a 24 hour basis and rapidly responsive to requests for its use.

The optimum use of neonatal intensive care units will occur when we can identify those high-risk pregnant women whose infants will require treatment and transfer the mothers to a hospital with a unit for delivery. Unfortunately, with present techniques, at least 20% of the infants who will require intensive care will not be delivered from identifiable high-risk mothers.[10] Therefore, every hospital delivering neonates must be capable and equipped to handle neonatal emergencies. To further support these hospitals an organized safe transport system must be available to transfer the infant to the regional center when emergencies occur.

Efforts at establishing a statewide program for providing intensive care for neonates in the state of Georgia have been begun. The initial reports indicate that the program has been successful in reducing perinatal morbidity and mortality. Development of the program is not complete and these services are



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25 (meclizine HCl) 25 mg. Tablets for vertigo*



Only 1 tablet B.I.D.

New convenience

Gantanol® DS

sulfamethoxazole/Roche

double-strength dosage form for acute cystitis* patients

*nonobstructed; due to susceptible organisms

New Gantanol® DS (sulfamethoxazole) tablets offer even greater convenience and economy for your patients with acute, nonobstructed cystitis due to susceptible strains of *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*...
The same amount of medication, the same efficacy, with only *half* the number of tablets per day.
Simplified dosage regimen encourages patient compliance: 2 tablets (1 Gm each) STAT—then 1 tablet B.I.D. for 10 to 14 days.
Clinical efficacy so basic you can start cystitis therapy even before culture results are available.

- In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

and economy

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter,* staphylococcus, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*), in the absence of obstructive uropathy or foreign bodies. Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially; then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: DS (double strength) tablets, 1 Gm sulfamethoxazole; Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

Basic therapy with convenience and economy:
Gantanol® (sulfamethoxazole)Roche®

Basic therapy with even more convenience and economy:
Gantanol® DS (sulfamethoxazole)Roche®

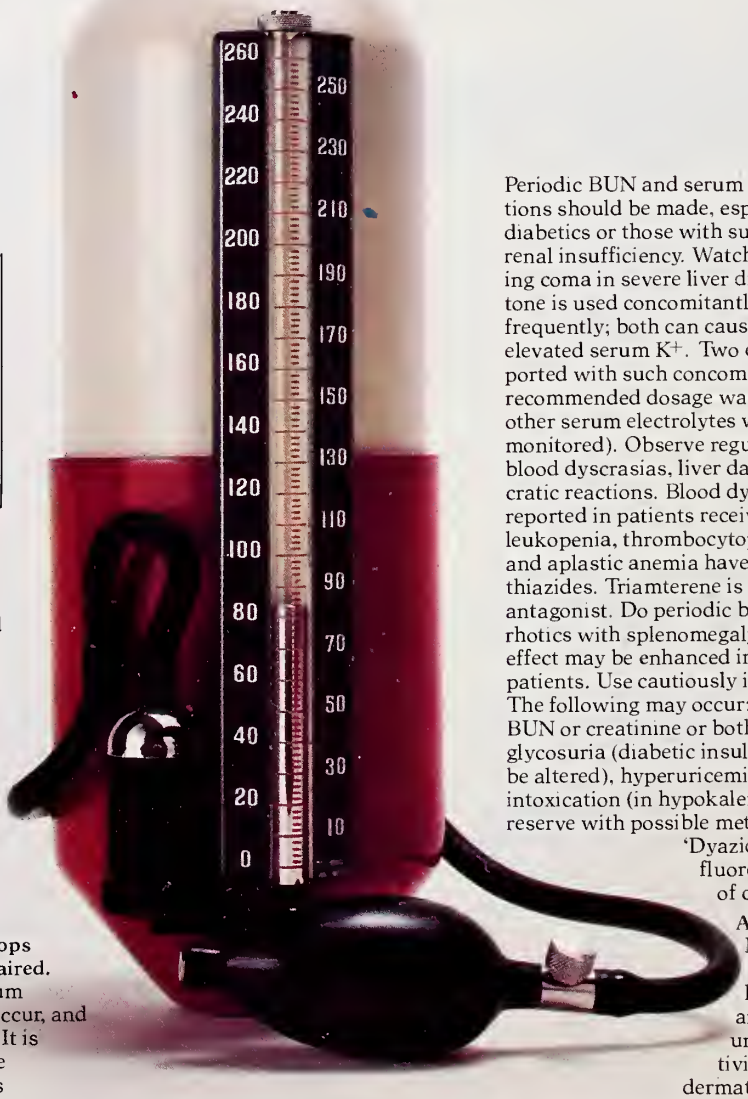
ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

TABLE IV

PROCEDURES REQUIRED BY NICU ADMISSIONS, 1975

Procedure	All Admissions No.	%	Outborn No.	%	Inborn No.	%
1. Umbilical vessel catheterization	167	36	118	35	49	38
2. Mechanical ventilation	158	34	117	35	41	32
3. Continuous distending pressure	115	25	92	28	23	18
4. Cardiac catheterization	43	9	39	12	4	3
5. Gastrointestinal surgery	28	6	21	6	7	5
6. Cardiac surgery	27	6	22	7	5	4

not yet available to all parts of the state at all times. Since the benefit to the infants is obvious we must all work toward the goal of statewide regionalization of perinatal care.

REFERENCES

1. Alden, E. R., Mandelhor, T. and Woodrum, D. E., etal.: Morbidity and mortality of infants weighing less than 1,000 gm in an intensive care nursery. *Pediatrics* 50: 40, (July), 1972.
2. Brown, A. K.: Plan for a Statewide System of Care for High-Risk Infants. Georgia Regional Medical Program, December, 1973.
3. Fitzhardinge, P. M.: Follow-up studies on the low birth weight infant. *Cl in Perinat.* 3:503 (September), 1976.
4. Gerard, P., Fox, W. W. and Outerbride, E. W., etal.: Early versus late introduction of continuous negative pressure in the management of the idiopathic respiratory distress syndrome. *J. of Pediatr.*
5. Health Services Research and Statistics, Division of Physical Health, Department of Human Resources.
6. Kanto, W. P. Jr. and Robertson, A. F. III: Procedures required during stabilization and transport of sick neonate. (Submitted for publication.)
7. Lubchenco, L. O., Delivoria-Papdopoulos, M. and Butterfield, L. J., et al.: Long-term follow-up studies of prematurely born infants I. Relationship of handicaps to nursery routines. *J. of Pediatr.* 80:50 (March), 1972.
8. Lubchenco, L. O., Delivoria-Papdopoulos, M. and Searls, P.: Long-term follow-up of prematurely born infants II. Influence of birth weight and gestational age on sequelae. *J. of Pediatr.* 80:509 (March), 1972.
9. Mockrin, L. D. and Bancalari, E. H.: Early versus delayed initiation of continuous negative pressure in infants with hyaline membrane disease. *J. of Pediatr.* 87:596 (October), 1975.
10. Nesbit, R. E. L. Jr.: Prenatal identification of the fetus at risk. *Cl in Perinat.* 1:213 (September), 1974.
11. Rawlings, G., Stewart, A. and Reynolds, E. O. R., et al.: Changing prognosis for infants of very low birth weight. *Lancet* 1:516 (March 13), 1971.
12. Schlesinger, E. R.: Neonatal intensive care. Planning for services and outcomes following care. *J. of Pediatr.* 82:916 (June), 1973.

INTERNIST/FAMILY PRACTITIONER: TIRED OF CITY TURMOIL?

Lake Elsinore, which is located only one hour south of Los Angeles and one hour north of San Diego needs you now. The area offers the best of living conditions in one of the most beautiful areas of California.

Due to population growth, we are now in need of two Internists and one Family Practice Physician. We offer excellent guaranteed income for first year with free office space and household move provided. If you want a busy practice away from city pressures, write with C.V. or call:

LAKEVIEW GENERAL HOSPITAL
Chris DiCicco, Administrator
P.O. Box 489
Lake Elsinore, California 92330
Telephone: (714) 674-1421

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office
480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

Important.....

It may be a totally new experience for you or it may be the continuation of a secondary career.....

As a doctor in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found. . . . service to the community, state and nation.

In addition, many persons have found that the change of place and change of pace has resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for Georgia Army National Guard units. These "drill" periods, as we call them, can be very flexible to suit the needs and training requirements of the unit. Physicians even receive monetary support for attending CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS. If you need that CHANGE OF PLACE and CHANGE OF PACE, contact



Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662



Internal Radiation Therapy of Liver Cancer

(90-Yttrium resin spheres intra-arterially) to supplement external radiation therapy, local and systemic chemotherapy

EDGAR D. GRADY, M.D., *Riverdale,*
THOMAS R. NOLAN, M.D., A. J. CRUMBLEY, M.D., *and*
A. R. ROSEN, M.D., *East Point*

In the past 12 years, we have reported treatment of 25 patients with liver cancer with intra-arterial 90-Y. While there has been considerable palliative help in over half the cases, few cases have had their disease controlled, but at least two were free of cancer at the time of death. Now, combining internal radiation therapy with external radiation, and sometimes with intra-arterial chemotherapy and systemic chemotherapy, we have four of the last five such patients with apparent control of their disease.

Earlier we reported our general experience with chemotherapy and radiation therapy together. When established liver cancer is demonstrated at time of colon resection, or when a non-resectable primary liver cancer is found at laparotomy, we believe it is of value to catheterize the hepatic artery at that time. Fluorescein dye may then be used to determine if the catheter is placed to infuse tumor and the entire liver. When liver disease is highly suspect or known, prior to laparotomy, a road map catheter femoral aortogram may be done preoperatively. Large tumors will get more circulation from the hepatic artery than do other parts of the liver. Aberrent hepatic arteries may also be seen and then appropriate cannulation can be planned. Percutaneous selective artery catheterization is a consideration for route of administration of intra-arterial radioactive particles, but care needs to be taken to pass the catheter past branches to the stomach and duodenum.

The following case reports describe the patients:

CASE #1 (B. P.)

A 58-year-old male was admitted to the hospital on 5-17-74 with abdominal pain and vomiting of two weeks' duration. He was found to have an obstructing lesion of the sigmoid colon, and therefore a transverse colostomy was done. After decompression was effected, he had a bowel cleansing and preparation for colon resection.

On 6-5-74, an anterior rectosigmoid resection was done, and the colostomy was closed at the same time. There developed a fecal fistula from a lower abdominal drain site, which closed spontaneously after a week of bowel rest and parenteral feeding. The pathology report showed adenocarcinoma of the colon extending through the bowel wall and metastasis to three of six lymph nodes. The patient

Associated with South Fulton Hospital. Dr. Grady's address is 33 Upper Riverdale Rd., Riverdale, 30274.

left the hospital in good condition on 6-29-74.

On 7-19-74, he was started on adjuvant 5 fluorouracil by mouth. His dose was 500-1500 mg. p.o. per week according to his tolerance. He was a mild diabetic, and at this time the diabetes became more difficult to manage; however, he continued the 5 Fu through December, 1974.

In January, 1975, evaluation now showed a defect in the left lobe of the liver by scan, and therefore he was re-hospitalized on 1-4-75. A catheter aortogram was done to delineate the hepatic arterial tree. CEA was found elevated to 10.1. Laparotomy demonstrated a solitary 5 cm. lesion of the left lobe of the liver as an obvious metastatic carcinoma. Soft nodes about the celiac axis were biopsied and proved negative. An hepatic artery catheter was placed and tied in place via the gastroduodenal artery, for chemotherapy and internal radiation therapy. Following the operation, 90-Y resin spheres were injected to give 5000 rads of internal radiation. The catheter was kept open with saline and heparin radiation. The catheter was kept open with saline and heparin daily until 3 weeks later when 5 fluorouracil was also begun. He was discharged on 2-8-75, from the hospital, to continue 5 Fu as an outpatient, 250 mg. per day, via the catheter, divided into 5-10 hourly injections.

He had some pain with intra-arterial 5 Fu, and developed jaundice on 2-25. 5 Fu was stopped. Repeat catheter arteriogram with priscoline and epinephrine on 2-12-75 showed a good hepatic arteriogram without definite areas of avascularity or neovascularity. The jaundice promptly subsided. On 4-1-75, 5 Fu was resumed at 250 mg. 2 to 3 times per week. Because of pain at the time of 5 Fu, and elevating alkaline phosphatase to 134, 5 Fu was stopped again after 2 months of treatment.

From 6-3 to 7-9-75, external radiation therapy with a 4 MeV linear accelerator was given focusing over the hepatic defect with a 17x14 cm. field. He received 3000 rads in 24 fractions via opposing fields. He had no further complications, recovering normal activity. The hepatic artery catheter was cut off below the skin on 8-21-75. Patient has continued to do well now with normal activities of a cattle farmer, doing much of his own work. CEA (nonsmoker) has dropped to 8.2 on 3-11-76, but the alkaline phosphatase is further elevated to 357(believed sequential to radiation therapy). There are no masses to palpation. Colon shows no evidence of recurrence by barium enema and sigmoidoscopy. X-ray of the chest remains normal.

Summary

A 58-year-old male had a staged anterior colon resection for carcinoma of the rectosigmoid. His lesion had penetrated through the serosa and invaded the mesenteric nodes. Six weeks postoperatively he was begun on adjuvant oral 5 Fu to tolerance and treated for six months. Now liver metastasis was detected by scan. Liver metastasis was treated by internal radiation with 5000 rads, administered by 90-yttrium resin spheres injected into an hepatic artery catheter. Intra-arterial 5 Fu was used for three months, during which time it was interrupted for 2 weeks because of transient jaundice. An additional 3000 rads externally focused on the liver defect were given 5 months after the internal radiation. Patient has recovered from his disease and treatment and apparently is in good health. Alkaline phosphatase has risen, while the CEA has fallen.

CASE #2 (C. H.)

A 24-year-old female was admitted to the hospital with massively enlarged liver of recent onset. There were multiple filling defects seen in liver scan, and x-rays showed displacement of the stomach and duodenum from the right. Arteriogram of the aorta showed normal anatomy of a vascular tree to the liver and on 9-19-73, laparotomy demonstrated multiple tumors from 3 to 8 cm. in diameter, scattered throughout the entire liver. Biopsies were taken, and a catheter was secured in the gastroduodenal artery for intra-hepatic artery injections later. Pathology report showed very cellular high grade hepatic cell carcinoma (hepatoma).

Treatment was by internal and external radiation therapy only. From 9-26-73 to 10-2-75, 4 MeV linear accelerator to entire liver gave 1600 rads tumor dose. On 10-5-73, she was given 20 mCi 90-yttrium resin spheres via the hepatic artery catheter, and on 10-9-73, a second dose of 20 mCi was given. Each fraction gave a tumor dose of 1526 rads or a total of approximately 3000 internally. Following this, she completed 2600 rads additional external radiation from 10-30-73 to 11-15-73, focusing on the largest hepatic defects demonstrated by scan. The total external dose was 4200 rads. Internal dose was 3000 rads. In both cases, we have evidence (focus from external and increased concentration of the isotope in the arterialized tumor) that more radiation went to the tumor masses than to the normal tissues.

All tumor has receded clinically. Patient is in excellent health without symptoms. The alpha-beta protein was not done before treatment, as it was not available then. Subsequently it has remained normal. CEA, alkaline phosphatase, SGOT and LDH are all normal.

Summary

A 24-year-old female with rapid development of

massive hepatoma, with grade IV cellularity, was treated successfully with internal and external radiation therapy to the liver. She had 3000 rads of intra-arterial 90-yttrium resin spheres administered in 2 equal fractions, 4 days apart. Her external radiation was focused on the entire liver for 1600 rads during one week, completing 5 days prior to the yttrium. Twenty-one days after the yttrium (which is approximately its radiation life) another 2600 rads were focused principally on the hepatic scan defects.

Patient has a total clinical recovery with no apparent residual disease 32 months after diagnosis and initiation of treatment.

CASE #3 (G. H.)

A 46-year-old male had an anterior resection of sigmoid colon carcinoma on 11-24-72. His lesion did not extend through the serosa, but was associated with several adjacent benign polyps and did show metastasis to the mesenteric lymph nodes. We had a good recovery without evidence of disease until 7-74, at which time a routine follow-up liver scan showed an obvious metastasis; there was an associated increase in alkaline phosphatase.

A catheter aortogram for demonstration of arterial architecture to the liver showed two hepatic arteries; the left came as usual from the celiac, and the right hepatic artery came from the superior mesenteric artery. On 8-13-74, at laparotomy, metastases were demonstrated in only the right lobe of the liver, but positive nodes were biopsied at the liver hilus. Catheters were placed in both hepatic arteries, directly into the right one and via the gastroduodenal for the left. Excellent fluorescence was obtained of the entire liver where both arteries were injected with fluorescein. Then 30 mCi 90-yttrium were injected into each catheter. Catheters were removed and the right hepatic and gastroduodenal arteries were both ligated. He had a severe febrile reaction and tachycardia post-operatively, presumably from ligating the right hepatic artery. He was treated with antibiotics to protect and treat the ischemic liver, and gradually recovered to go home doing well.

By 9-4-74 his condition was good enough to begin external radiation therapy, focusing on clip markers at site of positive node biopsy and in the areas of hepatic scan defects. During the next 6 weeks he received 4750 rads. This was tolerated poorly, requiring hospitalization from 9-12 to 10-5-74.

Patient slowly recovered and tolerated his situation well for a long while, but never regained much strength and remained undernourished, having lost a lot of weight during his therapy. He had very little discomfort, but was not able to return to work because of weakness. Anemia developed and persisted in spite of imferon and transfusions.

Readmission to the hospital was done 7-27-75. He developed hematemesis from gastritis. Ascites, peripheral edema and jaundice developed and progressed. Liver was now enlarged again. Because jaundice appeared obstructive, laparotomy was done again on 9-3-75. There was massive scar and edema around the common bile duct, with atresia and scar far up into the liver. No cancer was found, but extensive exploration was not felt warranted. He died 4 days later.

By combining up to four modes of therapy, encouraging results are reported in the treatment of this usually fatal disease.

Autopsy showed extensive scar about the bile radicals. There was tumor proliferation within the liver enmeshed in the fibrous stroma, where there were also areas of necrosis. No cancer was found outside the liver. Some superficial ulcerations were in the gastric mucosa.

Summary

This 46-year-old male had an anterior resection of sigmoid colon cancer with positive mesenteric nodes found in the surgical specimen. He developed metastatic liver cancer 20 months later. He had two hepatic arteries, the right coming off the superior mesenteric artery. 60 mCi of 90-yttrium were given, half into each artery. A positive hilar node was biopsied and marked at the same time. The right hepatic artery was ligated, and the patient had a severe fever and tachycardia, from which he recovered with antibiotics and support. 4250 rads of external radiation were added to the hilar area and focused on the hepatic scan defects. He developed radiation fibrosis and necrosis of the liver after a fairly good six months, and died with obstructive jaundice, which could not be relieved surgically. Autopsy showed residual cancer nests trapped in scar and associated with slight radiation necrosis.

CASE #4 (E. J. S.)

A 46-year-old female had first a loop colostomy of the transverse colon in 4-74, because of obstructing carcinoma of the descending colon. On 5-2-74, an anterior sigmoid colon resection with closure of the colostomy was done. The pathology report showed adenocarcinoma extending through the wall and into the mesenteric fat. There was metastasis to one of the eleven mesenteric nodes. A good post-

operative recovery occurred.

On 5-30-74, post-operative adjuvant 5 fluorouracil was begun orally. Dose was regulated (250-1000 mg. per week) according to anorexia and leukopenia (WBC was kept between 3100 and 4000) until she had six months of treatment (end of November).

Patient did well generally. Her first CEA done in following was 6.1 (0-5 was normal), on 5-19-75, and biochemistry profile showed no enzyme disturbance. Sigmoidoscopy, barium enema, chest x-ray and liver scan were all normal.

In 6-75, she developed pain in the right side of the abdomen, and right thigh and hip. By now the CEA rose to 41 (6-4-75). Biochemistry profile was still normal and liver scan was normal. She continued to have dull pain in the right abdomen and hip and by 10-21 CEA had risen to 235 and alkaline phosphatase was now up to 135.

On 11-19-75, exploration of the abdomen was done and there was found a solitary 4 x 5 cm. metastatic carcinoma of the left lobe of the liver. Needle biopsy was done of this and an enlarged lymph node near the liver hilus was excised as a biopsy (lying over the gastroduodenal artery). Both specimens were positive. Right gastric artery was ligated and a #3 Teflon catheter was passed retrogradely up the gastroduodenal artery to the hepatic and tied in place. Fluorescein dye showed excellent profusion by the catheter of the entire liver, with an increased fluorescence in the liver lesion itself. On the fourth post-operative day, intra-arterial 5 Fu was begun, using 1 cc. per 1-2 hours injected via the one-way stop valve placed in the catheter. After the last daily dose, 1000 units of heparin were injected. She tolerated from 100 to 250 mg. 5 Fu daily this way, but on some days she had only saline administered because of cumulative pain after the 5 Fu. On 1-20, systemic chemotherapy was begun with 190 mg. of methyl CCNU, Vincristine 1.5 mg. followed by 3 days of IV 5 Fu (300 mg. each). WBC now was hovering around 3200.

Internal radiation therapy with 90-Y resin spheres would have been done at this time but delivery of material was delayed, and therefore external radiation was begun. She received 3000 rads via the 4 MeV linear accelerator in 20 fractions over 28 days focused over the areas of the hilar node biopsy and the liver lesion.

The second part of her systemic chemotherapy was given March 22, 23, and 24 (1.5 mg. Vincristine IV x 1 and 300 mg. of 5 Fu IV daily x 3). WBC was now 4500.

On 5-14-76, she had her internal radiation to complete the local liver treatment, receiving 30 mCi of 90-Y resin spheres. A scan of the liver for distribution of the 90-Y showed some distribution throughout the liver, but more in the left lobe in the area of the disease. There was no complication from treatment. She still had pain in the right hip. CEA is down to 28 on 6-18-76, and the alkaline phosphatase has returned to 48. Bone scan and liver scan now show no evidence of disease, but she has had additional 2000 rads external radiation to the right lower quadrant of the abdomen and the right hip and a trial of decadron for symptoms.

Her pain is improved, in patient's opinion more from the decadron. She is completing systemic chemotherapy with methyl CCNU, 5 Fu and Vincristine on a regular maintenance schedule and getting along well.

Summary

This 46-year-old female had an anterior resection of the sigmoid colon carcinoma with positive nodes. Two months later she had an elevation of CEA. Exploration of the abdomen then showed a large metastasis of the left lobe of the liver and a positive node in the hilus of the liver. A catheter was placed in the hepatic artery and she received 5 Fu intra-arterially, followed by systemic 5 Fu, Vincristine and methyl CCNU. 3000 rads of external radiation therapy were given to cover the hilar nodes and the liver lesion. Then she had internal radiation with 90-Y. Some pain in the right hip persisted and though there was no evidence of disease, she received another 2000 rads of external radiation therapy to the para-aortic field (below the other field, and including the right hip).

She is now nearly free of pain and doing well, and is continuing on systemic chemotherapy on a regular schedule.

CASE #5 (B. S.)

A 71-year-old female had a right hemicolectomy for adenocarcinoma on 6-5-75. At that time two metastatic lesions of the liver, each 2 cm. in diameter, were seen in each lobe. Needle biopsy of the liver was also done (pathology was adenocarcinoma) and a Teflon catheter was secured in the gastroduodenal artery up to the level of the hepatic artery. Flourescein dye flouresced the left lobe of the tumor very well, but did not affect the right lobe.

Patient recovered from the procedure. Injection of ^{99m}Tc sulfur colloid into the catheter confirmed by scan that it only led to the left lobe of the liver.

A femoral artery catheter aortogram was done on 6-18-75, which revealed an anomalous origin of the right hepatic artery, off the superior mesenteric. Re-exploration of the abdomen was done on 6-20-75, and the right hepatic artery was catheterized with a Teflon catheter, which was tied in place. Fluorescein

injected in this catheter showed excellent fluorescence of the right lobe and its tumor. This latter finding was later confirmed by repeated injection and scan using 99m sulfur colloid.

Regional 5 Fu was begun now, using 100 mg. per day per catheter (divided hourly x 5-10), flushing with heparin at the end of the last injection each day. This was continued as an out-patient after discharge on 5-19-75. From time to time only saline and heparin were used for injection because of pain after the 5 Fu. 5 Fu was continued until 8-18-75, and at this time external radiation was begun. It was given with a 4 MeV linear accelerator in 27 fractions over the liver disease, totaling 2475 rads to the mid-plane of the liver.

There was a delay in production of 90-Y, and so catheters were kept open with daily saline and heparin, and 5 Fu was given at about 50 mg. per day per catheter about half the time from 10-16-75 to 1-15-76. At this time, because of further delay in production of 90-Y, she was given a course of methyl CCNU, 5 Fu and Vincristine (100 mg. methyl CCNU, 5 Fu 500 mg. daily x 4 IV and 1 mg. Vincristine on day 1—Vincristine repeated on day 36 and 5 Fu repeated day 36-39). Intra-arterial catheter 5 Fu was given again the last two weeks in March. The catheters were again kept open with saline and heparin. On 5-15-76, she had her 90-Y injected, delivering 20 mCi into each catheter. Scan of the liver, using the Bremstrahlung energy, showed good localization of the radioactive material in both lobes of the liver. Catheters were now cut off underneath the skin.

The patient has been doing well since then with no evidence of disease. During most of the therapy she has had some chronic epigastric and right upper quadrant abdominal pain. This has improved, requiring only Darvon compound irregularly for relief. Her lab work now shows normal complete blood count, CEA only slightly elevated to 5, alkaline phosphatase only slightly elevated to 149, LDH up to 259 and other elements of SMA-20 are normal.

Summary

This 71-year-old female had a right colectomy for adenocarcinoma and at that time had demonstrable metastases in both lobes of the liver. Catheters were placed to the right and left hepatic arteries, which had independent origins. She was treated with intra-arterial 5 Fu, external radiation therapy, systemic methyl CCNU, 5 Fu and Vincristine and intra-arterial 90-Y.

She is relatively asymptomatic and has no clinical evidence of disease now.

CONCLUSIONS

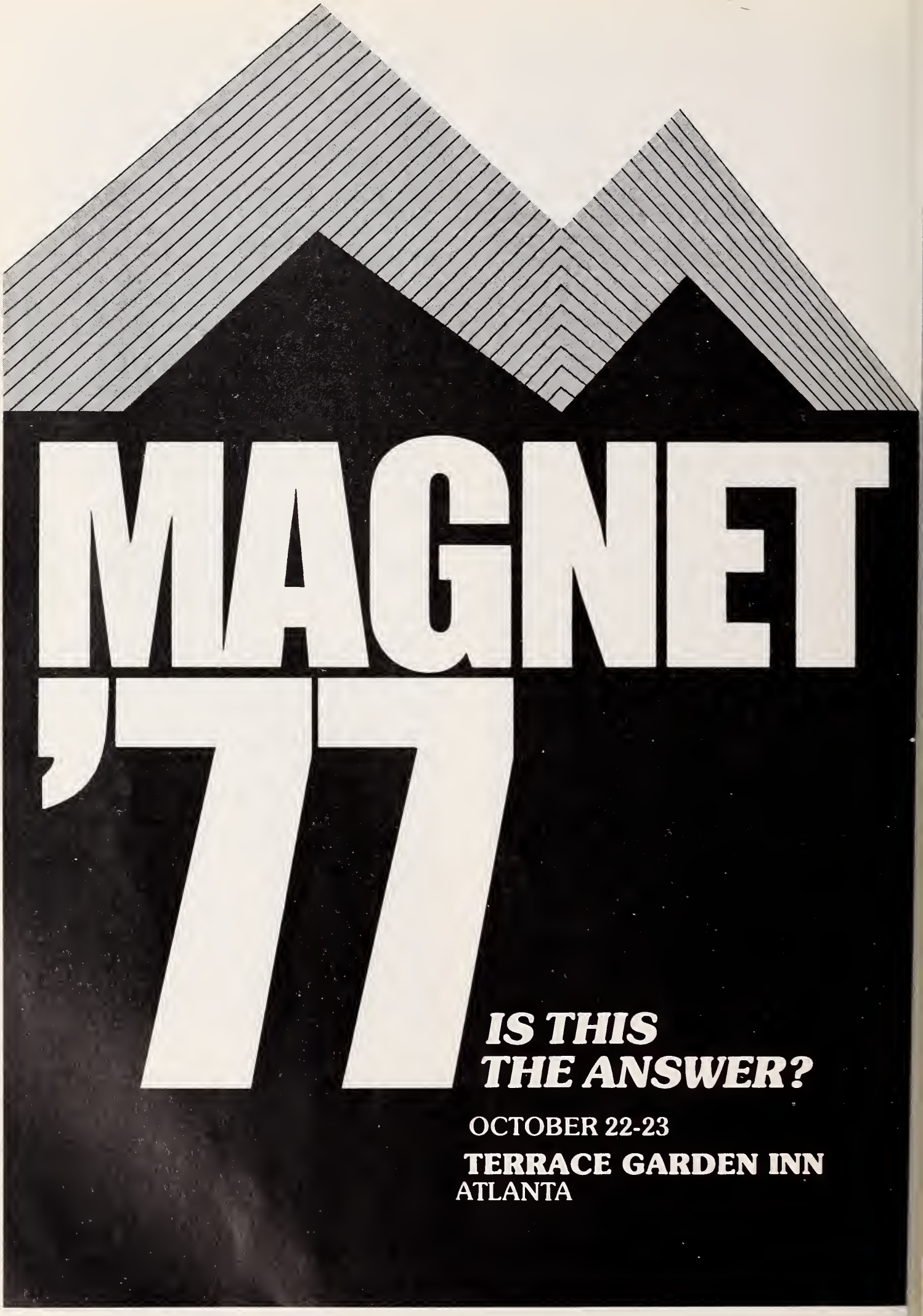
The liver tolerates judiciously planned fractionated external radiation, focused on principal disease. It may sequentially (before or afterwards) be treated with tapered, gradually expiring doses of internal radiation, again sent to the principal disease. Liver cancer can apparently be controlled by combining these modalities. Local and systemic chemotherapy seems to help assure disease control. The quality of life in the patients whose lives have been extended has been good, in their own and their families' opinions.

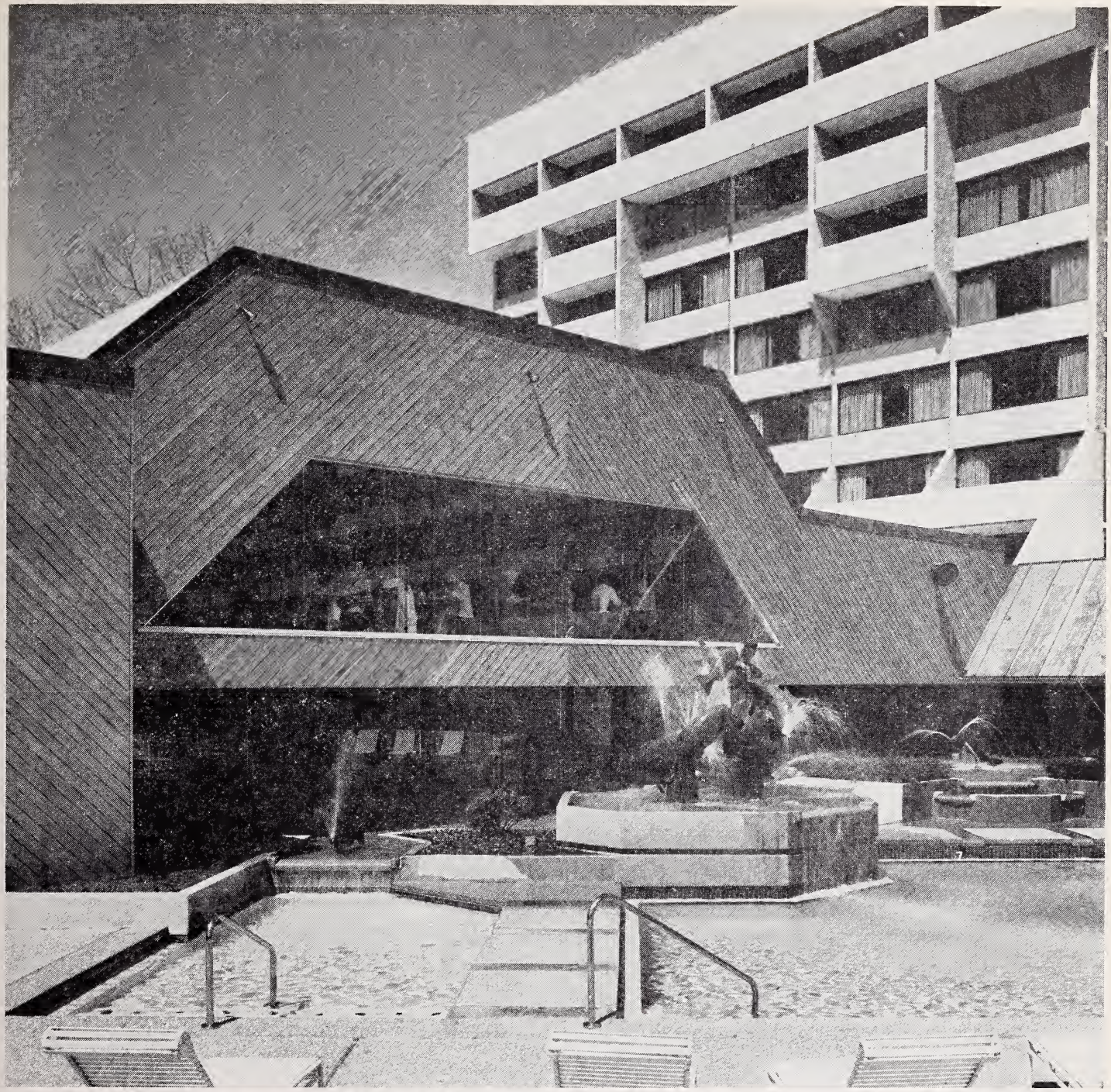
Acknowledgements: We are grateful to the Radiation Therapy Department of South Fulton Hospital for the cooperative planning and administration of the external radiation therapy with its 4 MeV linear accelerator.

Addendum: Since this article was submitted for publication, three patients have died, each showing progress of disease into organs other than the liver. When liver disease is reduced, slowed or eliminated, general metastases may have time to develop. All these patients had an extended period of productive comfort prior to death from: pulmonary spread, bone involvement, or cancer elsewhere in the abdomen. The fourth patient, primary in the liver, is apparently still free of disease, living a fully normal life as mother and housewife, four years after beginning her treatment.

BIBLIOGRAPHY

1. Nolan, Thomas R., Grady, Edgar D., Crumbley, A. J. and Cheek, W. V.: "Regional Internal Radiation for Hepatic Cancer." *Minerva Oncologica* 1:104, September, 1973.
2. Grady, E. D., Nolan, T. R., Crumbley, A. J. and Grady, C. K.: "Chemotherapy and Radiation Therapy Together to Treat Cancer." *Oncology* 24:118,1970.


MAGNET
'77
IS THIS
THE ANSWER?
OCTOBER 22-23
TERRACE GARDEN INN
ATLANTA



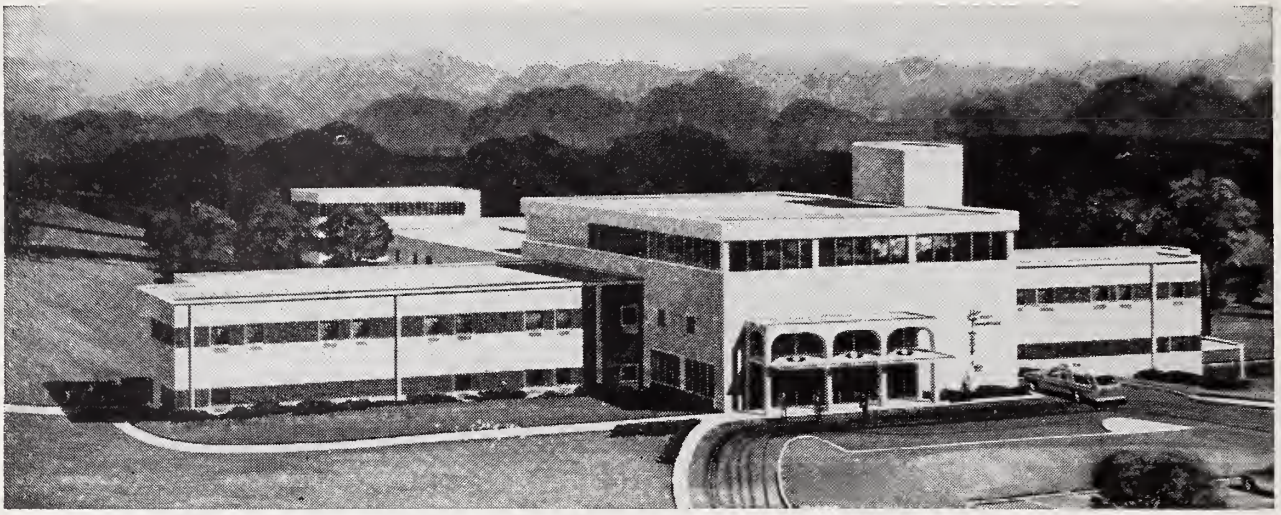
TERRACE GARDEN INN...

You'll Open Your Mouth Wide and say, "Ah-h-h, It's Beautiful!"

- Enjoy our luxurious rooms and suites.
- We're in a Prime Location—across from 200 stores including Neiman-Marcus, Saks Fifth Avenue, Lord & Taylor, Tiffany, Rich's.
- We're in Atlanta's prettiest residential and business area... and right off I-75-85.
- Dine in our dramatic, multi-level GARDENTREE RESTAURANT.
- For a fast bite, there's our bright, cheerful SUN FLOWER Coffee Shop.
- Play tennis on our professional courts with complete locker facilities. Rental equipment, too.
- Swim in our beautiful, cascading tiered pool.
- Have FUN in our Corner Hearth Lounge with live entertainment nightly (except Sunday).

Call Collect 404/261-9250 for reservations

Terrace Garden Inn
3405 Lenox Road Atlanta, Ga. 30326



HILL CREST HOSPITAL

FOR INTENSIVE TREATMENT OF PSYCHIATRIC DISORDERS

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR:
Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

This report was presented to the Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, United States House of Representatives, May 9, 1977, and is reprinted here in its entirety.

Statement by the American Medical Association on Unnecessary Surgery

JAMES H. SAMMONS, M.D.*

MR. CHAIRMAN and Members of the Subcommittee: I am James H. Sammons, M.D., Executive Vice President of the American Medical Association, and for 25 years prior to assuming that position I was a practicing family physician in Baytown, Texas, a suburb of Houston. With me today are C. H. William Ruhe, M.D., Senior Vice President, and Harry N. Peterson, Director of our Department of Legislation.

I wish to thank the Subcommittee for this opportunity to appear and to present the views of the Association on the issues before you.

It may very well turn out that, in presenting our testimony, I will not be in agreement with others whom you have heard on the subject before you. There is not 100 percent unanimity within the profession, and I count that as a strength of the profession, not as a weakness—and I say that without reservation despite all the problems it creates for us. It is this very diversity, in my judgment, which keeps the profession vital and creative.

One of the manifestations of this creativity is the self-criticism that the medical profession engages in. Over the past several days, and during the hearings you conducted in 1975, the Subcommittee had presented to it testimony regarding various studies made about various aspects of medical care. Most of them focused on some problem area in medical practice or raised questions about some aspect of medical practice.

In almost every instance, the study was conducted by a member of the medical profession and was published in a professional journal, published by an organization within organized medicine.

There are no doubt some members of the profession who might question the wisdom of this policy of open self-criticism, given the use to which some of the studies have been put over the past couple of years. However, I believe we must remain committed as a profession—and the AMA as an organization—to a policy of self-analysis and, when justified, self-criticism, in the interest of improved patient care. And we must remain equally committed to a policy of support for strong measures of self-discipline and self-help within the profession.

Support for Discipline and Peer Review

The AMA does not license doctors. But the AMA does strongly support effective mechanisms for discipline and peer review. These systems are being strengthened, and there is a new commitment by the medical profession and state medical licensing bodies to identify and remove from or appropriately restrict the practice of those physicians who ought not to be in practice or whose practices ought to be limited.

I am submitting for the Subcommittee the report of an AMA Ad Hoc Committee on Medical Discipline as adopted by our House of Delegates last December. Among other things, it notes that over 40 states have enacted legislation within the past two years to strengthen the licensing and disciplinary authority of state medical practice boards. These statutes have increased the bases on actions for which medical licensure boards may take disciplinary action against physicians and have created a broader range of flexible disciplinary mechanisms for the boards. The scope and applicability of the statutes, of course, vary from state to state. However, the amount of legislation introduced and enacted on this subject indicates a trend in state legislative activity which the American Medical Association believes should be encouraged in the interests of the public and

* Vice President of the AMA and Family Practitioner from Baytown, Texas.

the profession.

AMA Model Bills

The AMA has developed two model bills for state legislation on medical discipline. A number of the provisions of the AMA model legislation are reflected in the medical legislation enacted in the various states within the past two years.

One of the AMA bills would require hospitals and professional societies which discipline physicians to submit reports to the state board and provide for the maintenance of records of disciplinary actions against physicians by the boards. Immunity for those reporting or assisting the boards in their disciplinary efforts would also be provided. The immunity provisions should encourage physicians to be less hesitant in reporting to the boards when they have evidence of the professional incompetence or unfitness to practice of a colleague. Only when physicians report violations of the state medical practice act and are willing to testify if needed can the medical profession demonstrate to the public that the profession is fulfilling its responsibilities. The second model discipline bill would create a broad range of flexible disciplinary measures which medical licensure boards could take against physicians.

The AMA has also developed another model bill for state legislation to enable state medical boards to investigate and institute disciplinary or corrective measures for physicians suffering from mental or physical impairments, including alcohol or drug abuse, and deterioration through the aging process or loss of motor skill.

State Legislative Actions

The legislatures in at least 30 states have enacted legislation similar to the AMA model bill. The AMA and state medical societies have been instrumental in the enactment of many of these statutes. Twenty-five of our state medical societies have or are developing disabled physician programs.

Mandatory reporting of disciplinary actions taken by hospital medical staffs and medical societies is required in at least eleven states. Within the last two years thirty-one states have enacted statutes requiring reporting to the state medical boards of medical malpractice claims, settlements, and/or judgments.

Eighteen states have enacted legislation to mandate or permit the state medical board to mandate continuing medical education for physicians.

Discipline and Revocations

All of the efforts are beginning to show results. A survey currently being conducted by the AMA shows that in 35 states the number of disciplinary actions initiated against physicians by state medical licensure boards has increased from 277 in 1971 to 936 in 1976. Information from the Federation of State Medical Boards indicates that revocations of physician licenses by state medical boards has increased from about 47 in 1974 to over 139 in 1976. These statistics indicate revocations for disciplinary or similar reasons and do not include revocations for failure to pay license renewal fees or similar reasons.

With your permission, Mr. Chairman, I would like to enter into the record the comments of another Chairman Moss—or rather an erstwhile chairman, the former Senator Frank E. Moss, who was Chairman of the Subcommittee on Long-term Care at the time it conducted an inquiry into Medicare and Medicaid fraud. In a letter to AMA President Richard E. Palmer, M.D., last November 14, Senator Moss stated:

"The American Medical Association and its affiliates [sic] have played a central role in helping my Subcommittee spotlight Medicare and Medicaid fraud. In fact, the Illinois Medical Society, the Chicago Medical Society and the Illinois Physicians Union were directly responsible for my Subcommittee's exposure to the problem of 'Medicaid mills.' "

Medical Profession Activities

I have quoted Senator Moss and cited our model state legislation to establish that neither the medical profession nor organized medicine has any interest in protecting incompetence or fraud on the part of any physician. We have supported, and will continue to support, any legitimate effort to weed them out as well as any legitimate effort to improve the practice of medicine.

Indeed, most of the very mechanisms being cited today as methods to improve and insure the quality of medical care have originated with and been instituted by the medical profession. Peer review in its various forms, consultations, tissue committees, utilization review—all are mechanisms developed by the medical profession in the interest of improving patient care. But I would add one caveat: all of them were developed naturally as a part of the existing system of care and where they have been successful, it has been because they were accepted as an improvement in patient care by the medical community. I raise this point for a very important reason. The medical profession will accept and adopt any mechanism that offers promise for improved patient care if it is medically sound, and has been objectively tested and replicated—in short, if it has been shown to be scientifically valid.

Subcommittee Report

And that brings me directly to a point of sharp disagreement between the AMA and the Subcommittee over the report issued in January 1976 by the Subcommittee entitled "Cost and Quality of Health Care: Unnecessary Surgery."

Before addressing the issue of unnecessary surgery, I want to say once again we appreciate the opportunity to be here today to enter these remarks into the record and for the consideration I trust you will give to them. As you know, we prepared a response in depth to the Subcommittee report. To the best of my knowledge, it has never officially been entered into the record of the Subcommittee's hearings and so I would like at this time to request that it be included in the record.

In the expectation that it will be made a part of the record, I will not address all the points we raised in our response but will direct my remarks to the one basic assumption on which the report rests its conclusions. Mr. Chairman, I believe I can state without equivocation, and without fear of contradiction, that the medical profession is virtually unanimous in the belief that an opinion of "non-confirmed" by a consultant cannot be equated with "unnecessary" surgery, "deferred" surgery, "surplus" surgery or any other such word one chooses to use at the moment. Such an equation is neither medically sound nor scientifically valid, as I

hope to make clear in just a moment.

Consultation

Consultation is a hallowed and valuable adjunct of medical practice. The principles of medical ethics of the American Medical Association state that a physician should seek consultation in any difficult or questionable case. In seeking a consultation, a physician is seeking another judgment in an area where there is some basis for doubt. Most often he receives confirmation for his own diagnosis and therapy; sometimes the doubt is not resolved or is compounded and further consultation is warranted. But in all instances what he receives is another judgment—a professional but inescapably subjective judgment.

It cannot be otherwise because, for all the technological advances in medicine, we simply have not reached the point where tests supply all the answers. The tests have to be read and interpreted; more important, the particular patient must be observed and evaluated. And that is where professional judgment and personal skill come into play.

Further, for the Subcommittee's findings to be valid, it must be assumed that in every instance of disagreement, the opinion of the consultant must be the correct one.

"Second opinion" programs may be embraced by insurance companies and governments as an arbitrary device to ration medical care. However they are not of themselves a scientifically sound or medically valid method of determining the medical necessity of any procedure. A "second opinion" is just that and nothing more—an opinion which is, by definition, subjective. And it can never be anything other than that.

Decisions on Surgery

I would also like to address an assumption asserted by some that decisions for surgery are determined solely by the physician, and I would like to do so in the context of two surgical procedures often considered to be "benchmarks" for measuring the number of supposedly "unnecessary" operations. The two are tonsillectomy and hysterectomy. By using this approach, perhaps I can dispel some of the complexities, misunderstandings and false assumptions that underlie this whole issue.

What is an "unnecessary" operation? Who decides it? What criteria do they use to make the determination? Who decides whether to have the operation—the physician or the patient?

Some criteria would limit the decision to clinical evidence. That is too narrow an approach to the subject. It allows no basis for consideration of patient comfort, desire or quality of life. Any approach that eliminates those factors is a wrongful approach to medical care.

Tonsillectomy

Patient need or comfort *is* a factor in good medical care and can and should be considered as a factor in determining the validity of any medical procedure. This approach is set forth in a paper prepared by Mark V. Pauly, Ph.D., from the Center for Health Services and Policy Research at Northwestern University.

Very briefly, Dr. Pauly determines the "necessity" for a procedure—specifically tonsillectomy—on the basis of a cost-benefit ratio formula. And he introduces patient comfort or inconvenience as a factor in determining the cost-benefit ratio. To quote Dr. Pauly:

"Although hospitalization and surgery are expensive, the explicitness of these costs should not obscure the reality of other implicit costs of pain, uncertainty, discomfort or inconvenience borne by patients who are not hospitalized."

In other words there is a trade-off. It is true it may save the insurance company or the government some money to deny a patient an operation through a "second opinion" of "non-confirmed."

But at what cost to the patient in terms of pain or discomfort? And who should make that decision—the patient, the patient's physician, a consultant, an insurance company, the government?

Who makes the decision now? Mr. Chairman, oftentimes it is the patient—not the physician—who determines whether an operation is to be performed.

One clear example of this is to be found in the survey conducted by Dr. McCarthy who has appeared before you. To quote from a presentation in March of this year by Dr. McCarthy to the American College of Surgeons:

"One of the most disturbing findings to date, however, is the apparent high percentage of patients confirmed for surgery who elect not to have surgery performed. Twenty-nine per cent of the voluntary group and 12 per cent of the mandatory group *rejected the advice* of two physicians, at least one of whom was a Board certified surgical specialist" (Emphasis added).

This will not come as a surprise to any practicing physician. We have always been acutely aware that it is the patient who makes the ultimate decision on whether to take the medicine or have the operation.

Hysterectomies

The patient role is also a major factor in other surgeries, and I would like to illustrate this in discussing hysterectomies, the second operation that has been cited as often being "unnecessary."

It is a fact that the United States has the highest rate of hysterectomies in the world. The question is why.

Two factors in particular are responsible for the growth in the number of hysterectomies in recent years.

One is the use of hysterectomy as the means of sterilization. A study conducted about a year ago at the Los Angeles County Hospital revealed that 20 per cent of all hysterectomies performed there were for the purpose of sterilization.

The other factor is the use of the hysterectomy as a cancer prophylactic—once the uterus is removed, cancer of the cervix obviously becomes impossible.

By the strictest clinical standards, no hysterectomy performed simply as a convenient form of sterilization can be considered clinically "necessary." There is no diseased tissue, there is no pathology. It is clearly a case of patient "want" in contrast to patient "need." It is done at the request of and for the convenience of the patient, not at the insistence of or even the recommendation of the physician.

The woman wants it and is happier for having it. Is it a necessary or an unnecessary operation? Clinically —that is, approached on a pathological basis, it is not necessary. Medically—that is, approached on a patient basis, with the patient fully informed of all the conse-

quences, I'd say that it is beneficial to that patient and therefore is necessary.

Let me turn now to the second category of hysterectomies I mentioned—those done as prophylactic for cancer. It is my understanding the Subcommittee has information to the effect that, in a review of the costs and benefits of hysterectomies, the conclusion is reached that the benefits of hysterectomy for the purpose of cancer prevention are insufficient to justify the cost.

Mr. Chairman, I trust the Subcommittee is going to reject that advice. I cannot believe that a Subcommittee of the Congress of the United States is going to tell the women of this country that they cannot or should not have an operation that could avoid the agony and ultimate death by cancer because, according to some abstract formula, it is not "cost effective" and therefore unnecessary.

The medical profession is not unaware of the costs of medical care but costs—true costs—cannot be measured simply in fiscal terms.

Some 12,000 women die each year in this country of uterine cancer. If we could save most of those lives by hysterectomy, then I think the operations involved are both necessary and cost effective.

Subcommittee's Suggested Criteria for Surgical Procedures

Mr. Chairman, last fall you solicited our comments concerning the establishment of criteria for certain surgical procedures. We appreciated the opportunity to comment and did so after soliciting the advice of segments of the medical profession.

It appears to us from the nature of the request and from other evidence that the Subcommittee wishes to establish criteria for determining, under Medicare and Medicaid, when surgical procedures would be elective and for determining the necessity of a procedure.

If that is the intent of the Subcommittee, I hope I can dissuade you from doing so. Such an approach is contrary to sound medical practice.

As we stated in our letter to you, it is not the disease which determines whether the procedure is an emergency, but rather the condition of the patient and the time and circumstances under which the patient is seen by the physician. Or as was put by one of the medical specialists we canvased:

"I think we should emphasize that we are treating patients primarily and not diseases."

Mr. Chairman, we are not unaware of the cost of medical care to the nation today nor do we wish to be unresponsive to the expressed desire of the Subcommittee to insure the quality and cost-effectiveness of medical care. But an approach based on disease categories with hard and fast rules which allow for no variation is not medically sound or in the best interest of the patient.

There are generally accepted therapies for treatment of a given disease. But it is also true that there often is more than one *correct* way to manage a given medical problem.

It is also true that each patient is unique. And while statistically patients fall into a pattern, they must be treated on an individual basis.

We support and will support efforts to control costs that do not sacrifice the interests of the patient to the interest of some abstract cost-benefit ratio.

Rather than the criteria for surgical procedures suggested by the Subcommittee, we support the flexible approach taken under the PSRO program. While it is based on a set of guidelines which the AMA helped develop, it has sufficient flexibility built into it to allow for the individual exception. It protects the interest of the government without sacrificing the interest of the patient.

I believe that is your interest as well as ours.

I will be happy to answer any questions.

Scientific Assembly to Feature Workshop on Asthma

This year's expanded MAG Scientific Assembly on November 17-20 in Atlanta will include a new venture in interdisciplinary continuing education—a full-day workshop on Asthma. Co-sponsored by the Georgia Thoracic Society, the Georgia Lung Association, the Allergy and Immunology Society of Georgia, and Astra Pharmaceutical Company, the workshop is designed to meet the needs of primary care physicians, including family practitioners, pediatricians, internists, and pulmonary specialists. Newer and fundamental concepts in the diagnosis and management of asthma will be reviewed.

Featured guest faculty will be Raymond Slavin, M.D., St. Louis University School of Medicine; David Pearlman, M.D., University of Colorado Medical Center; Elliot Ellis, M.D., SUNY at Buffalo, and Myron Stein, M.D., UCLA. Workshop Chairman is David Tinkelman, M.D., of the Atlanta Lung Association's Medical Advisory Board.

So as not to conflict with other Scientific Assembly programs, the workshop will be held Thursday, November 17. Registration fee for the workshop is $15.00, which includes a working lunch. For further information, contact Betty Rafshoon at the Georgia Lung Association, 1383 Spring St., N. W., Atlanta 30309 (Tel. 404/876-3601).

Brochures describing the entire Scientific Assembly will be mailed to all MAG members in early September.

Ahlquist, Basic Research, and the Practice of Medicine

THIS EDITORIAL was almost entitled "Ray Who?," for it's doubtful that more than a handful of Georgia physicians had ever heard of Ray Ahlquist five years ago, except for those gallant survivors of his course in Pharmacology at the Medical College of Georgia. Now his name appears with monotonous regularity in medical journals, throw-aways, and the lay press as he receives international recognition for his research. Not to be outdone, the Medical Association of Georgia, by means of its official tongue, herewith raises its voice also, belatedly perhaps, but with unabashed pride.

Why all the hue? Propranolol, of course. According to Dr. DeBakey, it is "the most significant advance in the medical therapy of heart disease" since William Withering (1775) reported that the foxglove was useful for the dropsy. Most prescriptions are written for angina pectoris but also for assorted arrhythmias, obstructive cardiomyopathy, and increasingly for hypertension. Its application to diverse clinical states in which adrenergic activity plays a role is just beginning—hyperthyroidism, anxiety, Parkinsonian and essential tremor, migraine, and glaucoma, to mention a few. Even now more doses of propranolol than penicillin are dispensed. As a class, Beta-blockers are the most commonly used drug group in Europe today. Literally millions have benefitted. Among other honors, Ahlquist has received the Ciba Award of the American Heart Association and the prestigious Albert Lasker Award for Clinical Research. A goodly number of recipients of the latter have become Nobel Laureates.

The story of propranolol is rich with meaning for all of us who practice medicine or receive it. It started in 1947 when Ahlquist graded the reaction of a series of six sympathomimetic amines on vasoconstriction, the pupil, heart, gut, and uterus. He concluded that their action, inhibitory or excitatory, depended upon the site, and postulated that the relative density and distribution of two types of receptors (alpha and beta) must determine the opposing responses at different locations. This theory directly challenged the teaching of the great Harvard physiologist Walter Cannon, whose Olympian frowns no doubt encouraged the editorial rejection slip that followed the first submission of this report. The work was pure experimental physiology and hypothesis, with no clinical relevance intended or perceived. An English chemist, James Black, however, reasoned in 1962 that chemical sympathectomy of the heart

(beta blockade) might be helpful in angina pectoris. He had synthesized several such drugs, including propranolol. His predictions were confirmed in England in 1964-1966 and an unexpected salutory effect on hypertension was also observed.

The Food and Drug Administration permitted the sale of propranolol in 1968, with its use restricted to ventricular arrhythmias, pheochromocytoma, and obstructive cardiomyopathy.

Treatment of angina was not "approved" until 1972 and hypertension in 1976, a mystifying time-lag of about ten years for each condition. Curiously, the FDA is deaf to clinical trials from abroad but seems exquisitely sensitive to animal experiments. For example, four mice (in Canada) developed bladder tumors and triggered the saccharin ban. A million humans (in Europe), however, who ingested another beta blocker (metoprolol) for many years have not impressed the agency with its safety. With both drugs, of course, the critical toxicity studies, prolonged human usage involving teeming multitudes, have already been performed.

The pharmacology of sympathetic blockade has come a long way in 30 years, although this is not so obvious here. Eleven other beta-blockers with differing properties are marketed in Europe. Most useful to us would be one of several with selective cardiac effects (e.g., metoprolol). Cardiac beta-blockade would then be available for the legions of cardiacs with bronchospastic pulmonary disease which makes propranolol hazardous in this group.

Basic medical research in America is under pressure from many points. Its downward spiral can be documented in many ways. The average age of active investigators is steadily rising, for few of the young are filling the gaps created by death and retirement. The increase in salaried physician faculty merely parallels the exploding medical student population and clinical demands. Federal funding of medical research in constant dollars is less than in 1968 and more "targetted." The basic change probably is one in public attitudes demanding proof of immediately identifiable relevance. For example, even with the polio model freshly in mind, we are spending hundreds of millions of dollars this year on renal dialysis programs, but how much on fundamental research in renal disease? The bureaucratic and legal constraints imposed on research, particularly involving human subjects is demoralizing to the potential academic. So is the income gap between a research career and private practice. The soaring cost of medical education itself has had a negative effect. The debts accumulated during medical education can be repaid from an instructor's salary only with great pain. Young physicians today rarely perceive a research career as a viable alternative.

The cost of medical research has escalated at least as fast as human medical care. Ahlquist estimates the maximum cost of the experiments of 1947-48 at $3,500. This includes about $3,200 for his annual salary which also provided instruction in pharmacology for an entire class of 65 medical students. About $300 for supplies, animals, etc., was scraped from the departmental budget. Dogs from the local pound cost $1.00 each compared to about $40 today. Student laboratory equipment was used in the experiments. No external meddling, no technicians, no research grants, no administrative overhead.

So what does all this have to do with the practicing physician? Not much, if he doesn't care how medicine is practiced five, 20 or 100 years from now. If you've read this far, however, the description probably doesn't fit you. Most of us support one or more special health foundations—Heart, Cancer, Kidney, Rheumatology, etc., not to mention the Federal Government. Take a peek at the funds invested in basic research and compare them in percentages or inflation-diluted dollars with ten years ago. You will know what to do.

A. C. Witham, M.D.
Medical College of Georgia
Augusta, GA 30901

Harrison Rogers, Vice Speaker

HEEDING HORACE GREELEY, MAG's favorite son candidate went west and won the day. At the recent annual meeting of the American Medical Association in San Francisco, Harrison Rogers of Atlanta was elected Vice Speaker of the House of Delegates. Hearty congratulations are in order for his well-deserved victory.

We all know he will perform well in his new office, since we have seen him in action on the home front. During his years of service to the Medical Association of Georgia, initially as vice speaker for five years and speaker for another six years, his actions have confirmed adherence to the principles of impeccable integrity, clarity of action and above all, complete fairness to each and every delegate espousing any and all points of view. He has indeed proven his capability to "wield the gavel" with an even hand.

For backup support of our candidate, MAG organized a charter flight to San Francisco so as to have a large contingent from Georgia for campaign impact. The campaign workers obviously functioned well for their candidate.

Few candidates for AMA positions have gone into a campaign with such impressive credentials. He is Assistant Clinical Professor of Surgery at Emory University; Past President, Medical Association of Atlanta; Chairman, MAG Committee on National Legislation; Chairman, MAG Committee on Cost Accountability; member, Georgia Medical Political Action Committee; Chairman, Georgia Delegation to the AMA House of Delegates; Treasurer, Georgia Chapter American College of Surgeons; Past President, Emory Medical Alumni Association; on the Board of Directors, American Red Cross; on the Board of Directors, Atlanta Blue Shield; Georgia Chairman, Physicians for Ford Committee.

Congratulations again to a superior person. We know he will represent us well.

Edgar Woody Jr., M.D.
Editor

Thanks to Everyone

I WOULD LIKE to personally thank all members of the Medical Association of Georgia for their support of my campaign for Vice Speaker of the American Medical Association. Many of you wrote your delegate friends in the months prior to the convention or spoke with them at meetings, advocating my candidacy, and this was a decided advantage at the meeting. Most impressive, however, was the dedication of the Georgia doctors who not only carried on the business of the meeting but took on the hard work of the campaign willingly and did a superb job! It was a team effort, a successful one, and I sincerely appreciate your support.

Harrison L. Rogers Jr., M.D.
Atlanta

I've told this before . . .

(Editor's note: Unlike Dr. McDaniel's usual stories, this one will not make you laugh, but it's something to think about. . . .

Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

A Cruel Man

STRANGELY ENOUGH, the most cruel incident that I've ever known was perpetuated by a preacher.

Back in the '30s, several doctors and I owned a pack of fox hounds. This man that kept them with some of his own had a pickup truck and thrilled to the chase of a fox as much or more than we did.

We'll call him Dave Beckett. Dave had a job firing a furnace, which did not require too much brains, but a lot of brawn. And so during the Depression he had no problem with his job. It was pretty much like it is now: people want an easy position, but not a job entailing sweat and labor.

Dave had always had a hard life. At one time he was a great imbiber of corn whiskey on Saturday night and was known to have a huge temper. He was not afraid of anything or anybody and when he met a man of this same caliber, onlookers enjoyed a real show, very much unlike those on television. For this reason Dave had several scars on his face and neck, put there by some varmint that misunderstood him. I do not know what happened to the varmint.

And then Dave had a very sad experience. He had a five-to-six-year-old daughter who worshipped him and he her. When Dave was at home, she was his shadow. He took her to feed the dogs and to the grocery store and to the ice cream parlor. And when he was at home she insisted that he put her to bed with a big hug and kiss.

Mary Lou came down with a sore throat and they gave her the usual home remedies. His wife called the preacher, who came over and prayed for her and prayed and prayed. The next morning Dave put her in his truck and took her to Grady Hospital. They admitted her but she died from diphtheria.

This made a great change in Dave. He never drank any more corn whiskey, he never got in a fight again, nor did he even take the "Lord's name in vain." He was not a coward, but he was the kind of a man that looked an opponent in the eye and every time that I was ever with him the opponent backed down. It could have been that when he got upset, the scars on his face and neck changed colors and knowledgeable citizens understood this phenomenon.

The hot blast of the furnaces finally got to Dave and he came to see me one day with a big "knot" above his right clavicle. Examination and X rays revealed a far advanced cancer of the lung.

Dave was my friend, we had many happy hours together listening to our dogs

chase a fox. I gave him the true facts, as I did the family. He lasted about four to six weeks. I saw him a good many times and the preacher saw him several times a week.

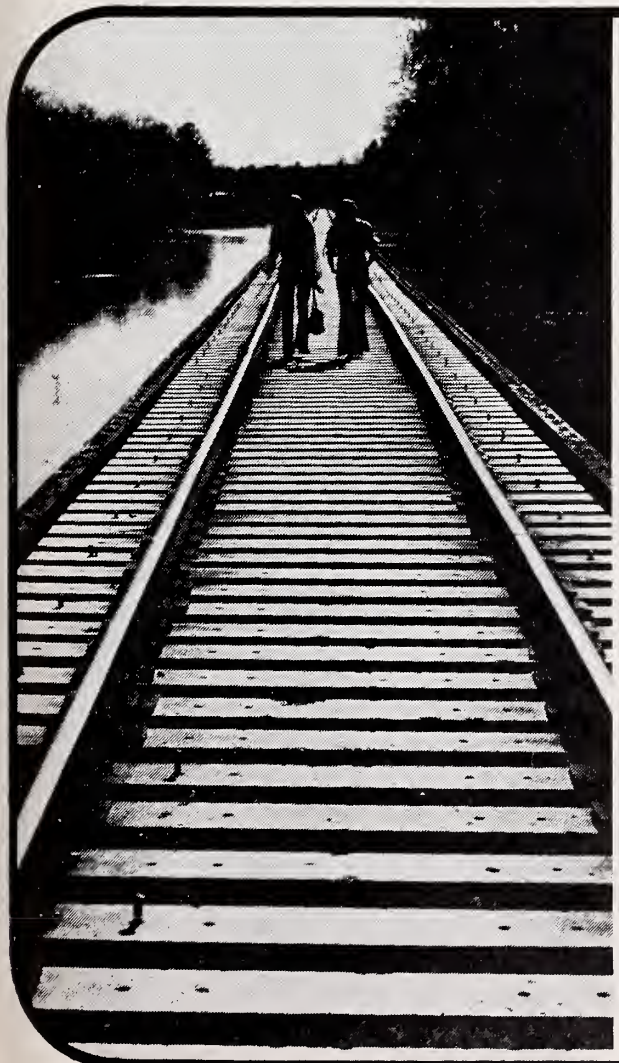
They had the funeral on Saturday afternoon at 3 o'clock. The church was a wooden building and would seat about 200 people. Up front was an elevated platform and a stand on which the preacher could put his Bible.

The church was packed with all of Dave's old fox hunting and other friends and his family's friends. Dr. O. D. Hall and I got about the last seats even though we were 15 minutes early.

The preacher was a "Hell-fire" and "damnation" preacher and he read all the scripture pertaining to that. Then when he gave the talk standing in front of Dave's casket, he said that it was such a pity that Dave was already in Hell and suffering the torment of eternal fire and brimstone. He went on to say that he had plead with him for days to be saved and baptized, but that Dave had always put him off. And now it was too late. He shook his head and said "Poor sinner, poor sinner. Burning in Hell!"

I heard the wife and children sobbing as well as some of the flock . . . and that's when we left.

J. G. McDaniel, M.D.
820 W. Wesley Rd., NW
Atlanta, Ga. 30327



After specializing in the treatment of alcoholism and drug addiction for 17 years, we found . . .

through caring and sharing if you're willing there's a way!

Willingway Hospital

BOX 508 STATESBORO, GA 30458 (912) 764-6236

Accredited by the Joint Commission on Accreditation of Hospitals

president's letter

Congratulations to Harrison Rogers



THE ANNUAL SESSION of the AMA held in San Francisco is now history, but I believe that all of you can be extremely proud of your past Speaker of the House of Delegates, Dr. Harrison L. "Jack" Rogers. As all of you probably know, Jack offered himself for the post of Vice Speaker of the House of Delegates of the AMA, and in a spirited campaign against two worthy opponents, won. I also believe that all of you can be very proud of the Georgia delegation and staff for the many hours of work which they did as your representatives as well as supporting Jack in his campaign. It truly was a professional effort.

I think we are most fortunate to have Jack Rogers as Vice Speaker and I know Georgia physicians will have more input into AMA deliberations because of Jack's presence at the Board of Trustees meetings which he will now attend.

As you know, this issue of the *Journal* devotes several pages to the deliberations and events at the AMA Annual Session. I urge you to familiarize yourself with them. I also know that all of you join with me in extending our heartiest congratulations to Jack Rogers.

Cordially,

Robert E. Perry Jr. M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia

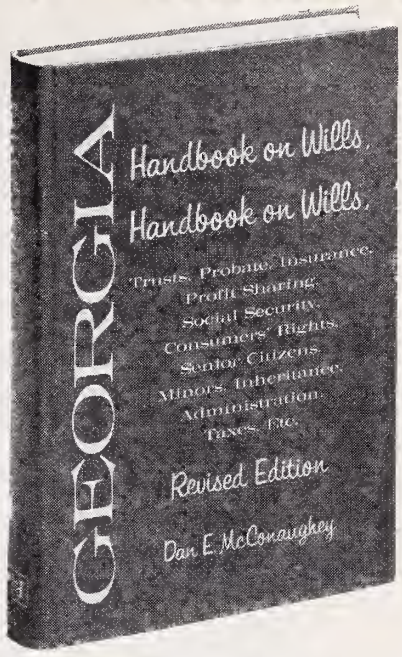


Dr. Harrison L. Rogers Jr. (center) at the AMA Convention in San Francisco. ***Photo by Dick Vincent.***

The general public has more interest in the field of Wills, Inheritance, and Administration of Estates than any other field of the law.

People constantly talk about what happens when a man dies without a will — or with a Will. Does the poor widow starve to death? How does a person contest a Will? Are attorney's fees and court costs fair or outrageous? Is there some gimmick that can eliminate all of these problems?

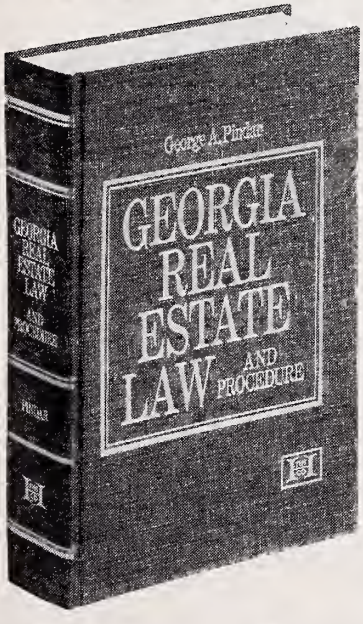
These questions and many others are answered in this valued book based strictly on Georgia law for Georgia citizens in language easy to understand.



Completely updated
New chapters added

*How NOT to invest your money
*Pension and profit sharing plans
*Consumer rights
*PLUS the Tax Reform Act of 1976 is discussed

Copyright 1976, 302 pages, dimensions 6" x 9", hardbound cover in brown, yellow and orange.



An Essential Tool for anyone dealing in Georgia Real Estate

No other book provides a more detailed coverage of the Georgia Law as it pertains to every phase of real estate.

This handsomely bound book is a must for the library of every person dealing with Georgia Real Estate Law.

WITH 1977 SUPPLEMENT

Copyright 1971, 6 3/4" x 10", 1,350 pages, Hardbound. Annual pocket part supplement.

ORDER CARD

Please enter my order for the publications listed below, including supplements, revisions and related material. I understand I may at any time cancel my order for the supplements, revisions, etc., by so informing The Harrison Company in writing.

☐ McConaughey's **GEORGIA HANDBOOK ON WILLS** $9.95
☐ Pindar's **GEORGIA REAL ESTATE LAW with '77 Supp.** $57.50

Georgia Residents Add 3% Sales Tax
(Add 1% MARTA or Local Option Sales Tax to all above prices where applicable)

Cash Sales are shipped postpaid. ALL OTHER SALES will have actual postage OR freight charges added.

Prices Subject to Change Without Notice

☐ Bill Personal Account ☐ Bill Firm Account
☐ I enclose check or money order for $———

Please Charge My ☐ BankAmericard ☐ Master Charge

MY BANK CREDIT CARD NUMBER IS

INTERBANK NO. ☐☐☐☐ EXP. DATE MO. YEAR

Name ———
Address ———
City ———
State ——— Zip ———
Date ——— Signature ———

ALL ORDERS MUST BE SIGNED 77-5S

THE HARRISON COMPANY, PUBLISHERS
3110 Crossing Park • Norcross, Georgia 30071 (404) 447-9150

legal page
legal page
legal page

Antitrust and the Health Industry—Straws in the Wind

RICHARD H. VINCENT AND GAIL H. TEPLIN, *Atlanta**

One result of the 1975 *Goldfarb* decision by the Supreme Court[1] has been to encourage antitrust enforcement agencies to take a fresh look at the "learned professions" for practices which may involve antitrust violations. Two recent speeches by government officials have sounded a warning to the health care industry that it may soon experience an increased level of antitrust enforcement.

Predicting expanded and intensified investigations into the health care field, Barbara A. Reeves of the Antitrust Division of the Department of Justice and Owen M. Johnson Jr., outgoing Director of the Federal Trade Commission Bureau of Competition, set forth the targeted areas in remarks before the National Health Lawyers Association on April 30, 1977. The following practices were identified as areas involving *possible* antitrust violations: (1) restraints on price competition (bans on advertising by physicians, use of relative value scales, and establishment of "usual and customary charges" by peer review committees); (2) restraints on alternative health care programs and practitioners (Health Maintenance Organizations, paraprofessionals, chiropractors and osteopaths); (3) exclusionary practices that limit the supply of physicians (AMA accreditation of medical schools, physician control of hospital staff privileges, certification of physicians by medical specialty boards and exclusive contracts between hospitals and physicians). A brief discussion of these areas will serve to identify the particular concerns of the enforcement agencies.

Price Competition

The Justice Department and FTC have taken the position that bans on advertising interfere with price competition by restricting the amount of price information which is disseminated to consumers of the service. The FTC is currently pressing its claim that the AMA has fixed prices of physicians' services by publication and enforcement of bans against advertising by physicians set out in its Principles of Medical Ethics;[2] a decision is expected by the FTC at any time. Bans on advertising by associations of other professionals, such as attorneys, accountants and dentists, have also been challenged. For example, the U.S. Supreme Court has recently decided a case involving advertising by attorneys, holding that a ban on attorney advertising imposed by a disciplinary rule of the Arizona Supreme Court violated the First Amendment protection of freedom of expression.[3] Although the restriction was also challenged on Sherman Antitrust Act grounds, the Court held that the rule constituted state action against which the Sherman Act was not intended to apply. The Court indicated that it was reserving judgment as to advertising by

* Prepared at the request of The Medical Association of Georgia. Mr. Vincent is a partner and Ms. Teplin is a summer associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C&S National Bank Bldg., 35 Broad Street, Atlanta, Georgia 30303.

other professions, which might raise different issues than the ones presented by *Bates*.

Also under attack as a restraint on price competition is the use of relative value scales, which list comparative numerical values for various medical and surgical procedures. Although these values are usually not expressed in monetary terms, the FTC objects to their use because (a) they make it convenient for physicians to fix prices across the board merely by agreeing to a uniform conversion factor, and (b) they tend to freeze the relationship between fees for different procedures —even though technological advances, etc., might change that relationship. Considerable publicity was generated last year when the FTC challenged use of relative value scales in complaints brought against the American College of Obstetricians and Gynecologists and the American Academy of Orthopedic Surgeons, and these two national organizations finally consented to discontinue the use of relative value scales.[4] More recently the Justice Department has filed civil antitrust suits against the Illinois Podiatry Society and the American Society of Anesthesiologists, seeking injunctions against their use of relative value scales.[5]

Peer review committees have also been identified as a potential source of restriction on price competition. Although Ms. Reeves acknowledged that peer review committees do provide quality control regulation of the delivery of medical services, she emphasized that the Justice Department is "alert for any sign that such committees are becoming a forum for increasing fees." The Justice Department has recently approved peer review committees of the International Chiropractors Association on the basis that they are acting in a purely advisory capacity in mediating fee disputes between third-party reimbursement organizations and chiropractors.[6] The Justice Department has warned, however, that it could change its position if an intent to control or increase fees is disclosed in the future.

Restraints on Alternative Health Care Programs and Practitioners

The FTC and Justice Department are scrutinizing physicians, hospitals and medical societies for any signs of artificial restrictions on alternative health care programs and practitioners. According to Ms. Reeves, the Justice Department is particularly concerned that health maintenance organizations (HMOs) are given an opportunity to demonstrate their merits and are not subjected to anti-competitive restrictions. The FTC is also concerned with HMOs and has obtained a consent order from two medical service corporations which it claims have boycotted HMOs, HMO physicians and other physicians who practice on other than a fee-for-service basis.[7]

Mr. Johnson predicted that the FTC may soon be investigating hospitals that deny the use of their facilities to osteopaths and chiropractors. Private suits have also been brought by chiropractors against medical societies and health insurance corporations, alleging antitrust violations.[8]

Restrictions on paraprofessionals is another area that the Justice Department considers ripe for antitrust enforcement. Where medical societies prohibit paraprofessionals from performing certain functions that are permissible under state statutes, the Justice Department intends to investigate whether these restrictions are necessary quality controls for the protection of the public or are a response to a perceived economic threat.

Another type of activity that the Justice Department considers anti-competitive is exemplified by the 1973 U.S. Supreme Court case[9] in which the Alabama Board of Optometry was enjoined from attempting to eliminate the corporate practice of optometry. Because the Board was composed of independent optometrists who stood to gain economically from such restriction, the Justice Department considered this situation a restraint on competition.

Exclusionary Practices

The FTC has attacked the AMA's involvement in accreditation of medical

schools as a conflict of interest,[10] a situation which theoretically could be used to limit the supply of physicians. As a result, the federal committee responsible for extending the authority of the Liaison Committee on Medical Education (LCME), the medical school accrediting arm of the AMA, has continued the LCME's authority for two rather than four years and has ordered it to weaken its ties to the AMA.

If the granting and denial of hospital staff privileges is used to exclude physicians for other than legitimate reasons, this may be a restraint on competition according to the Justice Department. Other practices cited by the Justice Department that can be used as tools to limit the supply of physicians are arbitrary denials of certification of doctors by medical specialty boards and exclusive contracts between hospitals and physicians which, due to the number of hospitals in the area and reasons for such contracts, unreasonably restrict competition.

Conclusion

As this area of the law is very much in flux, it is difficult to predict the outcomes of many of the new investigations being made into the health care field by the antitrust enforcement agencies. The antitrust cases that the Justice Department has pending against the health care sector involve civil, rather than criminal, remedies. In areas where the law is unsettled or where the issues have not been previously litigated, the Justice Department intends to continue seeking only civil remedies. After it has been established that a certain practice is a clear antitrust violation, however, criminal penalties will be sought by the Justice Department in its cases against the health care industry. Potential antitrust violations have been spelled out by the Justice Department and FTC in an effort to encourage the medical profession to reexamine these areas and hopefully to avoid future controversy.

REFERENCES

1. *Goldfarb v. Virginia State Bar,* 421 U.S. 773 (1975).
2. [1973-1976 Transfer Binder] Trade Reg. Rep. (CCH) ¶21,068.
3. *Bates v. State Bar of Arizona,* 45 U.S.L.W. 4895 (decided June 27, 1977).
4. 3 Trade Reg. Rep. (CCH) ¶21,171.
5. *United States v. Illinois Podiatry Soc'y, Inc.,* Civil No. 77 C 501 (N.D. Ill., filed Feb. 14, 1977); *United States v. American Soc'y of Anesthesiologists, Inc.,* Civil No. 75-4640 (S.D.N.Y., filed Sept. 22, 1975).
6. No. 276 Trade Reg. Rep. (CCH) at 7 (April 12, 1977).
7. 3 Trade Reg. Rep. (CCH) ¶21,195.
8. *E.g., Wilk v. American Medical Ass'n,* No. 76 C 3777 (N.D. Ill., filed October 13, 1976).
9. *Gibson v. Berryhill,* 411 U.S. 564 (1973).
10. Business Week, April 25, 1977, at 102.

QUALITY PRINTING SERVICES FOR DOCTORS

You Design It – We Print It

OFFICE FORMS

℞ PADS

UNIFORM INSURANCE CLAIM FORMS

MAG SERVICES INCORPORATED

LETTERHEAD STATIONARY

ENVELOPES

APPOINTMENT CARDS

STATEMENTS

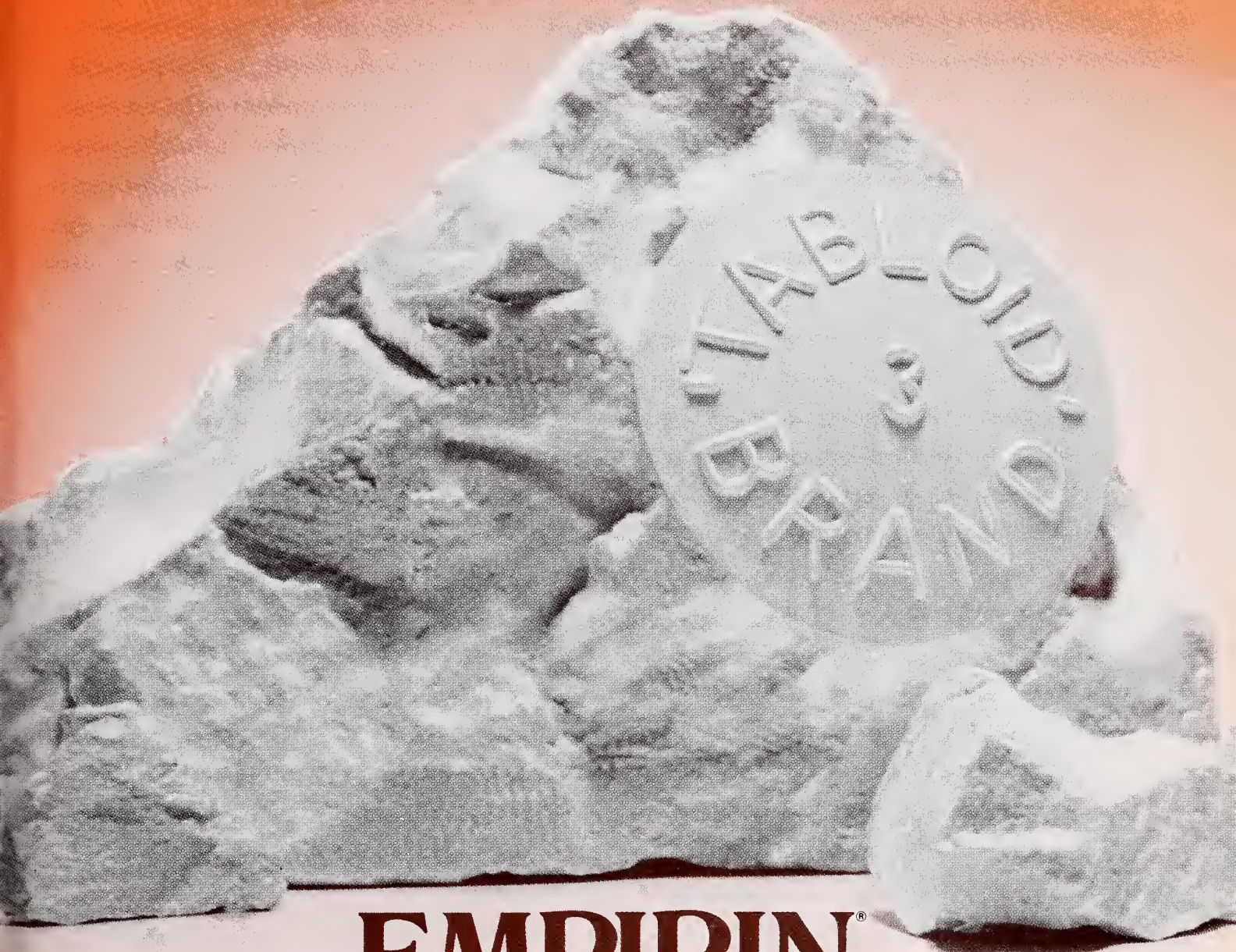
CALL OR WRITE FOR A QUOTATION FOR ANY PRINTING NEED

MAG SERVICES, INC.

A Service Company of the Medical Association of Georgia

968 Peachtree Street, N.E., Atlanta, Georgia 30309 (404) 876-7535

B.W. CO.® MAKES CODEINE ANALGESICS. YOU MAKE THE CHOICE.



EMPIRIN®
COMPOUND c̄ CODEINE #3

Each tablet contains: codeine phosphate, 32 mg (gr ½), (Warning: May be habit-forming); aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg. CIII

The classic codeine pain reliever

For decades, Empirin Compound c̄ Codeine #3 has provided potent analgesia plus the anti-inflammatory action of aspirin for consistently dependable pain relief in the majority of your pain patients. Brand name quality at reasonable cost; readily available in hospital and local pharmacies.

Plus CIII prescribing convenience: up to 5 refills in 6 months (where state law permits), and telephone prescribing permissible in most states. See page 3 of advertisement for prescribing information.

NOW...

LOOKING DIFFERENT CAN BE AS IMPORTANT AS BEING DIFFERENT.



Introducing the peach-colored acetaminophen/codeine tablet

EMPRACET™

c̄ CODEINE #3

Each tablet contains: codeine phosphate, 30 mg (gr ½), (Warning: May be habit-forming); and acetaminophen, 300 mg. C III

Empracet c̄ Codeine #3: non-aspirin/codeine pain reliever for aspirin-sensitive patients

EMPRACET c̄ Codeine #3 offers you an alternative with advantages for your aspirin-sensitive patients, those with bleeding disorders and "...patients undergoing surgical procedures associated with significant blood loss such as tonsillectomies, open heart surgery, and scoliosis repair...."*

NEW LOOK

Not the same old green and black capsule with a "revised formula." Not a white tablet with aspirin-associations. New peach-colored EMPRACET c̄ Codeine #3 looks different from the leading codeine combination products. It doesn't contain aspirin, so it doesn't look like aspirin—imparting greater reassurance to patients leary of taking it by mistake. It also avoids confusion with other tablets in the household.

NEW NAME

Not a household word, the new name may play a positive role in your pain patient's subjective reaction to your prescription.

EMPRACET c̄ Codeine #3. New look. New name. Psychologically more acceptable to your patients. And with CIII prescribing convenience for you—up to 5 refills in 6 months at your discretion (where state law permits), and telephone prescribing permissible in most states.

*Czapek EE: *JAMA* 235:636, 1976.

EMPIRIN® COMPOUND with CODEINE (III)

Contraindications: Hypersensitivity to aspirin, phenacetin, caffeine or codeine.

Warnings: See **Warnings** below.

Precautions: ***Allergic:*** Precautions should be taken in administering salicylates to patients with active peptic ulcers and those with known allergies; patients with nasal polyps are especially likely to be hypersensitive to the medication. SEE ADDITIONAL PRECAUTIONS BELOW.

Adverse Reactions: Most frequent adverse reactions are listed below. Some patients taking salicylates develop nausea and vomiting. Hypersensitivity may be manifested by skin rash or anaphylactic reaction. With these exceptions, most side effects occur after repeated administration of large doses; include headache, vertigo, ringing in ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin.

Phenacetin side effects usually result from overdosage. Cyanosis, acute hemolytic anemia, skin lesions, and fever may appear with toxic doses. Continued abuse may lead to renal damage.

Caffeine side effects almost always result from overdosage; include insomnia, restlessness, excitement, tense muscles, and diuresis. Tachycardia and extra systoles may be observed.

EMPRACET™ with Codeine Phosphate, 30 mg, No. 3 (III)

Contraindications: Hypersensitivity to acetaminophen or codeine.

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS AND DRUG INTERACTIONS COMMON TO BOTH PRODUCTS

Warnings: ***Drug dependence.*** Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: ***Head injury and increased intracranial pressure.*** Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

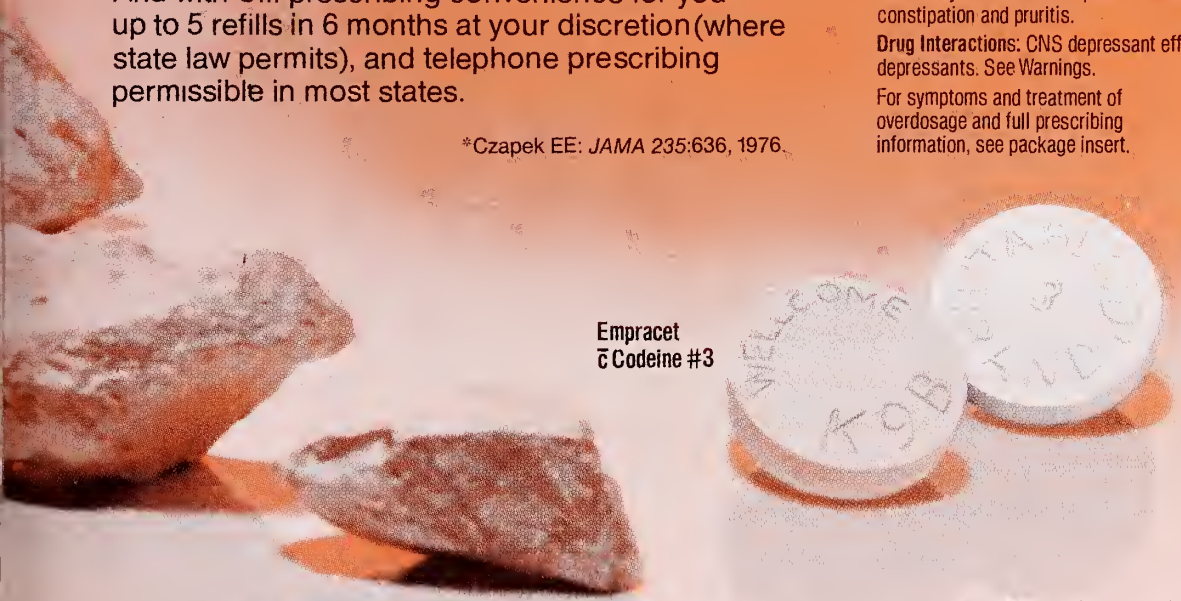
Adverse Reactions: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritis.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



Empracet c̄ Codeine #3

Empirin Compound c̄ Codeine #3

YOUR CHOICE OF CODEINE ANALGESICS FROM BURROUGHS WELLCOME CO.

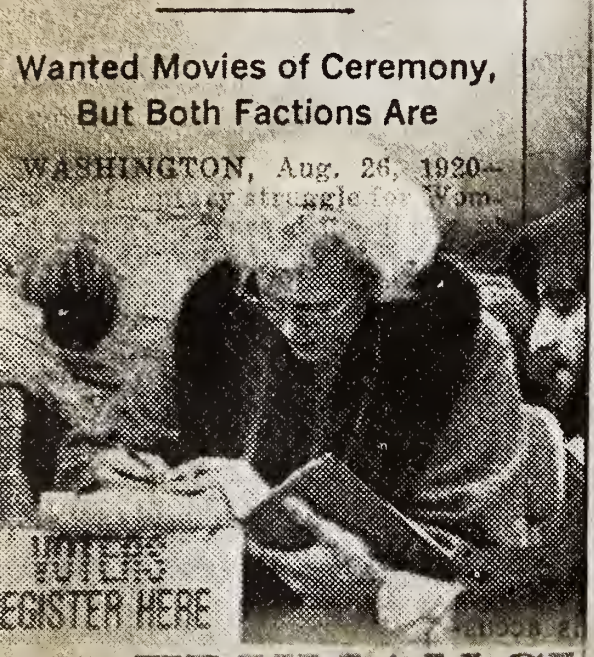
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws—He Ca the Measure 'Cornerstone' of His Economic Progran

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt called the m "the cornerstone in a str which is being [illegible] mea[illegible]s comple[illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen[illegible]

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGNI the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005



METROPOLITAN PSYCHIATRIC

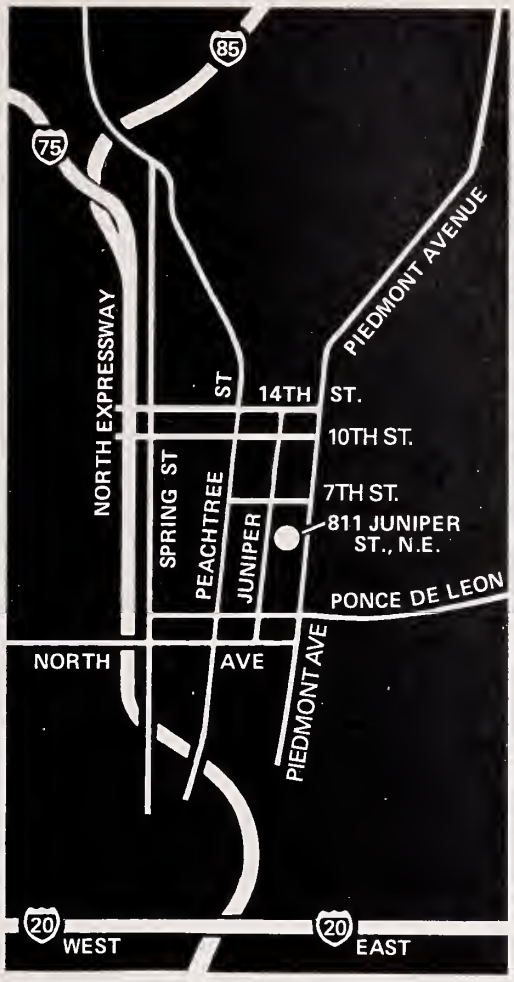
METROPOLITAN PSYCHIATRIC CENTER, centrally located in midtown Atlanta, provides comprehensive services for adult and adolescent patients in the area of psychiatry and alcohol and drugs. Inpatient care, outpatient care and partial hospitalization programs are available at the Center.

In the Psychiatric Program, the attending psychiatrist determines from the comprehensive services available the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

mily Counseling
ychological Testing
cial Work Services
ucational Tutoring
cational Rehabilitation Counseling
ll Radiology Services
ctivity Therapy Programs including Occupational
erapy, Recreational Therapy and Art Therapy

Georgian Clinic Program, directed towards the
very of persons addicted to alcohol or drugs, offers a
ctured yet personalized experience drawing upon a
e range of treatment modalities. Through the

Grumet, M.D.
cal Director

Custis L. Rosser, M.H.A.
Administrator

ge Dominick, M. Div.
tor, Georgian Clinic Program

combined resources of the Center for Psychotherapy Inc., the Atlanta Internal Medicine, P.A., and the Metropolitan Psychiatric Center staff, the following services are included:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling
- Pastoral Counseling Services

Additional information on the Psychiatric Program may be obtained by contacting Dottie Fitchett, Admissions. For information on the Georgian Clinic Program, call 876-8655. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

opolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

heart page
heart page
heart page

Current Concepts: Exercise and Coronary Disease

JOHN D. CANTWELL, M.D., *Atlanta**

In 1799, James Easton published (at his own expense) a volume on human longevity, recording information of 1,712 persons who lived for a century or longer. He noted that "man is by nature a field animal and seems destined to rise with the sun and to spend a large portion of his time in the open air, to inure his body to robust exercises. . . ." He went on to say that "it is not the rich and the great, not those who depend on medicine, who become old, but such as use much exercise, for an idler never attains a remarkable old age."

John Quincy Adams was an advocate of regular exercise. Ben Franklin, in his written comments on education, advised that students be kept "in health, and to strengthen and render active their bodies, they be frequently exercised in running, leaping, wrestling, and swimming." When Adams asked Franklin if he practiced what he preached, the latter replied, "Yes, I walk a league (about 3 miles) every day in my chamber. I walk quick and for an hour, so that I go a league. I make a point of religion of it."

Exercise and Coronary Risk

There has been recent interest in the role of exercise and coronary heart disease. Considerable animal experimental data supports the beneficial effects of exercise on cardiac structure and function, including enhancement of the coronary macro- and micro-circulatory system, the collateral circulation, and myocardial performance and efficiency. In humans (both normals and post-coronary patients) physical training generally results in increased oxygen uptake, improved cardiac output, and a reduction of myocardial oxygen demands (i.e. lower systolic blood pressure —heart rate product) for a given work load.

---

* Director, Preventive Cardiology Clinic, Atlanta, and Associate Director of Cardiac Rehabilitation, Georgia Baptist Medical Center, 300 Boulevard, NE, Atlanta, GA 30312.

Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, care of the Georgia Heart Association, Broadview Plaza Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

Retrospective and prospective studies show definite trends that the more exercise one gets at work or during leisure hours, the lower the coronary risk. Recent data on 10,079 former major league baseball players indicate that they live longer than the average white male population. Third basemen lived the longest, followed by shortstops and catchers. Pitchers, first basemen, and managers were at the opposite end of the spectrum. There were some interesting aspects pertaining to the quality of player and his life span; those with a batting average above .300 lived longer than those whose average was below .200, but not as long as the players with a batting average between .200 and .249. Perhaps there is some advantage to mediocrity after all.

As for the effect of physical training on the coronary risk factors, serum triglyceride levels are decreased, as are systolic and diastolic blood pressure readings (particularly when the blood pressure was elevated to begin with). Past studies on cholesterol have been inconclusive, although recently Wood, et al., may have provided at least part of the answer to the exercise-cholesterol relationship by showing that vigorous exercise may actually increase high density lipoprotein (HDL) levels (which seem inversely correlated with coronary risk). Some postulate that HDL stimulates intracellular lecithin cholesteryl acyl transferase (LCAT), thereby facilitating cholesterol removal from the cell. Others feel that the HDL molecule is preferentially transported to the liver for excretion and less likely to be incorporated into atherosclerotic plaques. Such observations are speculative and need to be supported by further studies.

Physical training may facilitate weight loss, lessen ventricular ectopy, and enhance fibrinolysis or clot breakdown. In assessing the latter, one needs to take into account the levels of obesity, for overweight subjects have reduced fibrinolytic activity (perhaps relating to their more sedentary living habits). Patients with coronary disease have less of an exercise-related fibrinolytic response than do those without this disease. Since the fibrinolytic response varies with the intensity of exercise, patients whose exercise tolerance is severely limited due to angina pectoris may show no significant effects on their fibrinolytic activity.

A recent cross-sectional study of nearly 3,000 men showed inverse correlations between physical fitness levels (based on oxygen uptake analysis) and selected coronary risk factors. In comparing the various fitness groups, the following trends were noted:

Fitness Group	*Cholesterol*	*Trig.*	*Glucose*	*Uric Acid*	*BP Sys.*	*Dias.*	*% Body Fat*
Very poor	229.9	176.8	111.0	6.7	127.6	83.4	26.1
Fair	226.9	138.7	105.6	6.7	124.4	83.2	24.0
Excellent	221.1	98.3	103.4	6.4	122.9	81.4	20.8

While the above doesn't prove cause and effect, it does show that the highly fit person has a significantly lower coronary risk profile than does the unfit individual.

Prescribing Exercise

Physical fitness has several components which can be remembered by the appropriate acronym—SAFE.

S = strength
A = ability (or skill)
F = flexibility
E = endurance.

While all are important, the cardiologist is particularly interested in endurance exercise. The President's Council on Physical Fitness got evaluations on 14 popular forms of exercise from seven experts. Each exercise was looked at from the standpoint of heart and lung endurance, muscular endurance, muscular strength, flexibility, balance, and general well-being (weight control, muscle definition, digestion, sleep). The overall rating were as follows:

Exercise	*Total Rating (points)*
Jogging	148
Bicycling	142
Swimming	140
Handball/squash	140
Basketball	134
Tennis	128
Calisthenics	126
Walking	102
Golf (cart)	66
Softball	64
Bowling	51

In prescribing exercise for a middle-aged or older individual, it is important to first take a thorough medical history and perform a physical examination. A resting ECG should be followed by a treadmill or bicycle exercise test to see how the heart performs under stress. If the latter is normal, the person is given an exercise prescription based on the concept of the target heart rate.

In order to develop a high level of fitness, one needs to perform exercises during which the heart rate is elevated to between 70-85 percent of the maximum rate for that age group. This is what is known as the target heart rate for exercise. The maximum heart rate decreases with age and, accordingly, so will the target heart rate:

Age	*Maximal Heart Rate (bpm)*	*70-85% Target Heart Rate*
20	200	140-170
30	190	133-162
40	180	126-153
50	170	119-145
60	160	112-136
70	150	105-128

For example, a 50-year-old man who had a maximum heart rate of 170 beats per minute on the treadmill test should exercise at an intensity to elevate the pulse rate to between 119-145 beats per minute. The individual can be easily instructed in checking his own pulse rate. Each exercise session should be preceded by and followed by 5-minute warmup and cool-down periods, should be at least 15-20 minutes in duration, and should be done at a frequency of 3-5 times per week.

Patients with heart disease should confine such vigorous activity to medically supervised exercise classes but may walk and do flexibility exercises on their own.

Summary

Animal experimental data provides overwhelming evidence that vigorous exercise has a beneficial effect on the animal heart. These effects are more impressive in the younger animals. In certain older animals and in others who were intensively exercised, deterioration was observed in some of the heart muscle's energy-producing "factories" (or mitochondria). It is always tenuous to extrapolate animal data to humans. Realizing these limitations, one can say that moderate aerobic exercise, begun early in life, would seem a prudent measure.

There have been at least 40-50 studies in man which have attempted to correlate physical activity habits and coronary heart disease rates. As in the animal experimental data, evidence shows a strong trend that coronary disease is less prevalent in the physically active. Dr. Kenneth Cooper's data, and our observations in the Preventive Cardiology Clinic, indicate a reduction in certain coronary risk factors (such as blood pressure and blood lipid levels) in those with high cardiopulmonary endurance levels.

It would be virtually impossible to prove beyond a shadow of a doubt that vigorous exercise prevents or appreciably delays the onset of coronary disease. Such a study would necessitate thousands of subjects, randomly assigned to either a long-term exercise group or to a non-exercise group. They would need to be followed for upwards of 25 years which would be quite costly and would discourage scientific investigators who are accustomed to coming up with answers in

a shorter period of time. The drop-out rate would be high in the exercise group and a significant number in the control group would exercise on their own. In the meantime, it may be wise to heed the advice of Immanual Kant:

"It is often necessary to make a decision on the basis of information sufficient for action, but insufficient to satisfy the intellect."

SELECTED REFERENCES

1. Fletcher, G. F. and Cantwell, J. D.: *Exercise and Coronary Heart Disease.* Springfield, Ill., C. C Thomas, 1974.
2. Wood, P. D., Klein, H., Lewis, S. et al.: Plasma lipoprotein concentrations in middle-aged male runners. (abstr.) Circulation (Suppl. II) 40 & 50:III-115, 1974.
3. Cooper, K. H., Pollock, M. L., Martin, R. P. et al.: Physical fitness levels vs. selected coronary risk factors. JAMA 236:116-169, 1976.

From the Journal 50 Years Ago

(Editor's Note: This appeared on page 69 of the February 1927 edition of the JOURNAL.)

A Few Essentials for a Successful Medical Society

P. C. QUARTERMAN, M.D.,
Valdosta, Ga.

Earnest desire for a large attendance at meetings.
Learn what you can by paying strict attention to scientific papers.
Eliminate all prejudice against any member of your society.
Visit indifferent members and insist on them attending meetings with you.
Enter into discussions on subjects interesting to you.
Never fail to read scientific papers when requested to do so.
Think of yourself when you criticise others that are putting forth their best efforts.
Help members on subjects that you are more familiar than they are.

Discourage unjust criticism of other members of your society.
Instigate all members in whatever they undertake to make the society more profitable.
Strengthen your organization by getting all eligible members.
Try to aid your officers in every way possible.
Remember the success of the society is dependent upon your efforts.
Interest county societies in your Eleventh District Society.
Concentrate your thoughts on subjects under consideration.
Timidity in meetings should be overcome.

Membership dues should be paid promptly.
Entertain your society as a pleasure and not as a duty.
Devote due time and consideration to having interesting programs.

Substantial gains are made through true fellowship.
Omit excessive stimulation, it is not best for your society, and too, the rolling pin may await you at home.
Concise papers are the best, don't ramble all around the world, you may get lost.
Insist on co-operation, for unity is power.
Evolution is O.K., but do not monkey with outside affairs.
This is one of the best societies in the state, and it is
YOURS. What shall we do with it in 1927?



Driving the 308GTB puts you in an entirely different world of automotive experience. To quote *Autocar*—"All round, one is lost in admiration for the superb quality of the mechanical engineering, the standard of finish of the body and interior details, and the all-round efficiency. It is the best Ferrari we have driven."

Test drive the 308GTB as our guest (it's priced about the same as some Mercedes and Porsche models). Driving will never be the same after you experience Ferrari. You will have known the Ferrari mystique.

DO ALL DOCTORS DRIVE MERCEDES?

No. Some enjoy the unique experience only a Ferrari delivers.



faf motorcars inc

AUTHORIZED FERRARI SALES • SERVICE • PARTS

3862 Stephens Court, Tucker, Ga. 30084 **(404) 939-5464**

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

Medical Meeting Calendar

SEPTEMBER

8-11—*Hilton Head, SC;* **BORDERLINE CONDITIONS:** Category 1 Credit; Contact: Georgia Psychiatric Association, c/o Fred L. Greiner, M.D., 1970 Cliff Valley Way, N. E., Atlanta 30329, PH:404/875-3063.

10—*Lake Lanier Islands;* **GEORGIA GASTROINTESTINAL ENDOSCOPY SOCIETY ORGANIZATIONAL MEETING;** Contact: Julius Wenger, M.D., VA Hospital, 1670 Clairmont Rd., N. E., Atlanta 30329, PH: 404/321-6111.

10-11—*Lake Lanier Islands;* **GEORGIA GASTROENTEROLOGIC SOCIETY ANNUAL SCIENTIFIC MEETING;** Contact: David Hein, M.D., 340 Boulevard, N. E., Atlanta 30312, PH: 523-1969.

16-18—*Atlanta;* **GEORGIA HEART ASSOCIATION'S 29TH ANNUAL MEETING AND SCIENTIFIC SESSIONS;** Category 1 Credit; Contact: Georgia Heart Association, 2581 Piedmont Rd., N. E., Atlanta 30324.

24-25—*Callaway Gardens;* **GEORGIA AND ALABAMA SOCIETIES OF ANESTHESIOLOGISTS MEETING;** Category 1 Credit; Contact: Z. W. Gramling, M.D., Medical College of Georgia, Augusta 30902.

29-30—*Atlanta;* **CLINICAL CARE OF RHEUMATIC DISEASES;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Director of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

OCTOBER

3-4—*Chattanooga;* **TENNESSEE VALLEY MEDICAL ASSEMBLY;** Category 1 Credit; Contact: Chattanooga-Hamilton County Medical Society; Chattanooga.

3-7—*Augusta;* **THIRTEENTH ANNUAL FAMILY PRACTICE SYMPOSIUM;** Category 1 Credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901; PH: 404/828-3967.

3-14—*Correspondence Course;* **PRIMARY CARE FOR THE NEWBORN, 1977 SECOND EDITION;** Category 1 Credit; Contact: Ga. Academy of Family Physicians Educational Foundation, Miss Camille Day, Exec. Dir., 11 Corporate Square, Suite 205, Atlanta 30329, PH: 404/321-7445.

4—*Fort Oglethorpe;* **INFECTIOUS DISEASES;** Category 1 Credit; Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital; Fort Oglethorpe 30742.

5-7—*Atlanta;* **SEXUAL COUNSELING OF ABLE BODIED AND PHYSICALLY DISABLED ADULTS;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

5-8—*Pine Mountain;* **PSYCHIATRIC INSTITUTE ON GROUP BEHAVIOR AND GROUP LEADERSHIP;** Category 1 Credit; Contact: Associate Dean for CME; Emory University School of Medicine, 69 Butler St., Atlanta 30303, PH: 404/659-1676.

10-14—*Gainesville, FL;* **6th FAMILY PRACTICE REVIEW;** Category 1 Credit; Contact: Mr. Bill Rockwood, Coordinator, University of Florida, Div. of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville, FL, PH: 904/392-3143.

12-13—*Atlanta;* **GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS, FALL SCIENTIFIC MEETING;** Category 1 Credit; Contact; James W. Bennett, M.D., Program Chairman, 1467 Harper St., Augusta 30902.

13-14—*Atlanta;* **REHABILITATION OF THE PATIENT WITH SENSORY LOSS;** Category 1 Credit; Samuel B. Chyatte, M.D., Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

13-15—*Atlanta;* **AMERICAN SCHOOL HEALTH ASSOCIATION MEETING;** Contact: Mr. Stephen Jerrick, Exec. Dir., P. O. Box 416, Kent, OH 44240.

14-15—*Atlanta;* **RICHARD W. TELINDE SYMPOSIUM ON GYNECOLOGY;** Category 1 Credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., Atlanta 30303, PH: 404/659-1676.

22-23—*Atlanta;* **1977 MAGNET CONFERENCE** (Practice Management); Contact: Mr. Charles B. Templeton, Medical Association of Georgia, 938 Peachtree St., N. E., Atlanta 30309, PH: 404/876-7535 or Toll Free 1-800-282-0224.

28-29—*Atlanta;* **THIRD INTERDISCIPLINARY SYMPOSIUM ON CANCER-RELATED PROBLEMS;** Category 1 Credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., Atlanta 30303; PH: 404/659-1676.

28-29—*Callaway Gardens;* **1977 CME SEMINAR ON INFECTIOUS DISEASES** (for PAs); Contact: Physician Associate Program, Div. of Allied Health Professions, Emory University School of Medicine, P. O. Box 22095, Atlanta 30322.

NOVEMBER

6-9—*Dallas, TX,* **SOUTHERN MEDICAL ASSOCIATION 71ST ANNUAL SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Scientific Assembly, Southern Medical Association, 2601 Highland Ave., Birmingham, AL 35205.

15—*Kingsport, TN;* **PHYSICIANS' CONTINUING EDUCATION SERIES;** Category 1 Credit; Contact: Glen E. Garrison, M.D., Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

17-19—*Atlanta;* **SECOND ANNUAL CONFERENCE ON PHYSICAL IMPAIRMENT AND DISABILITY: "BACK PAIN";** Category 1 Credit; Contact: Mrs. Ethel B. Warner, Center for Rehabilitation Medicine, Emory University, 1441 Clifton Rd., N. E., Atlanta 30322.

17-20—*Atlanta;* **MAG 1977 Scientific Assembly;** Category 1 Credit; Contact: MAG Scientific Assembly, 938 Peachtree St., N. E., Atlanta 30309, PH: 404/876-7535 or INWATS 800-282-0224.

30-Dec. 4—*Atlanta;* **SECOND SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE** sponsored by Peachford Hospital and Georgia Academy of Family Physicians; Category 1 Credit; Contact: Conway Hunter, Jr., M.D., 2151 Peachford Rd., Atlanta 30341.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.


260
240
220
200
250
230
210
190
170
150
130
90
Lidov

When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study[1] Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate[2]

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Zaroxolyn®

(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:
1. Dornfeld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* **18:** 527-533, 1975
2. Data on file, Medical Department, Pennwalt Prescription Products.

PENNWALT
Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester New York 14603

This is not a solicitation or an offer to sell or buy any securities. Such an offer is made by prospectus only.

Preferred Partnerships inc.



Re: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Sir;

How much income tax are you now paying? We can help you shelter a portion of your present income---plus show you how you can receive a Tax-Free return.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that give you a better tax write-off. We have investments in the $5,000-$8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

NEW MEMBERS

Baydar, Isik D., F-P-C—Act—IM
508 N. Main St., Cedartown 30125

Betz, Charles J., F-P-C—Act—GP
Floyd Hospital, Rome 30161

Briones, William K., F-P-C—Act—GP
100 John Maddox Dr., Rome 30161

Burk, Billy D., F-P-C—Act—ObG
16 Professional Court, Rome 30161

Clairmont, Albert A., MAA—Act—Oto
Suite 6404, 25 Prescott St., NE Atlanta 30308

Dixon, Albert V. Jr., Dougherty—Act—CHP
Suite 5, 1009 N. Monroe, Albany 31707

Fajman, William A., MAA—A—R
Emory University Dept. Nuclear Medicine, Atlanta 30322

Fletcher, H. Quigg, Muscogee—Act—GS
P.O. Box 736, Columbus 31908

Gadlage, Robert A., DeKalb—Act—PS
5040 Snapfinger Woods Dr., Decatur 30035

Gimpel, Amnon, MAA—Act—P
1970 Cliff Valley Rd., NE, Atlanta 30329

Joshi, Yogesh K. K., Cobb—Act—ObG
2404 Austell Rd., Austell 30001

Lokey, Julian L., MAA—Act—On
Suite 400, 315 Boulevard, NE Atlanta 30312

McKenzie, E. William, W-C-D—Act—ObG
787 Chickamauga Ave., Rossville 30741

Medina, Oscar D., DeKalb—Act—GP
3290 Memorial Dr., Decatur 30030

Mudarry, May I., MAA—A
Grady Memorial Hospital, Atlanta 30303

Oguz, Sadi, W-C-D—Act—P
Hutcheson Memorial Hospital, Ft. Oglethorpe 30742

Sidler, Leonard O. Jr., MAA—A—IM
80 Butler St., SE, Atlanta 30303

Tinkelman, David G., Cobb—Act—A
Suite 201, 2480 Windy Hill Rd., Marietta 30067

Tison, James H., Ocmulgee—Act—IM
717 Griffin St., Eastman 31023

Voss, Craig A., F-P-C—Act—Pth
321 Turner McCall Blvd., Rome 30161

Zaki, Afaf A. A. K., DeKalb—Act
Emory University Clinic, Atlanta 30322

PERSONALS

First District

The American Academy of Family Physicians announced recently that **James C. Freeman, M.D., C. G. Green, M.D.,** and **W. R. Kent, M.D.,** have completed continuing education requirements to retain active membership in the association.

Fourth District

George T. Henry, M.D., completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Carlos A. Selmonosky, M.D., and **James S. Blanc, M.D.,** co-authored a paper "Thoracic Outlet Syndrome Diagnostic Problems and Results of Surgery" which was read by Dr. Selmonosky at the European Society of Cardiovascular Surgery meeting held in Tel Aviv in late May.

Fifth District

The Tuskegee, Alabama, Veterans Administration Hospital has honored **Asa G. Yancey, M.D.,** by naming a surgical seminar after him. Dr. Yancey, Medical Director of Grady Memorial Hospital in Atlanta, was cited for his outstanding accomplishments and contributions to the field of surgery. During his tour as Chief of Surgery at Tuskegee, 1948-1958, he founded and directed the first residency training program open to black surgeons in Alabama. In 1958, he duplicated that effort in Georgia, at the Hughes Spalding Pavilion in Atlanta. Dr. Yancey is Professor of Surgery and Associate Dean at the Emory University School of Medicine.

Harry L. Cheves, M.D., has been elected President of the Southern District Medical Society. Dr. Cheves is on the staff at South Fulton Hospital in East Point, where he presently serves as Chairman of the Medical Records Committee.

Earlier this summer, **Joseph Dimon, M.D., Brown Dennis, M.D.,** and **David Stacy, M.D.,** helped police rescue and ambulance personnel save the life of a drowning youth. Atlanta Municipal Court Judge Arthur M. Kaplan, in a letter to the *Atlanta Constitution* said,

Capital Cadillac

SELLS AND LEASES
CADILLACS
FOR LESS THAN
ANY OTHER DEALER
IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

Practice where the big premium is on medical care.

Not on high overhead. Or paperwork. Or any of the other hassles that keep chipping away at your clinical time.

If you want more out of your medical career, consider what the Navy can offer. A ready-made practice where patients' medical care is independent of the fluctuations of the economy. An engaging life-style. Adventure. Travel. And as much as $30,000 to $40,000 a year to start.

This year the Navy needs General Practitioners for the Flight Surgeon program, for Undersea Medicine, and as General Medical Officers. We also need specialists in Anesthesiology, Family Practice, Psychiatry, Internal Medicine, Neurology, Radiology, Pathology, and Pediatrics. If your interests lie in any of these clinical areas, and you'd like to get back to pure medicine, the Navy is for you. Get all the facts from your local Navy medical recruiter.

Fewer than 200 physicians are needed, so don't delay.

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

"It was heartwarming and gratifying to see these three men on their hands and knees assisting in cardiopulmonary resuscitation in its most difficult form for at least 45 minutes and giving of themselves until they were near exhaustion. It is my privilege to bring the heroic and meritorious acts of these dedicated people to your attention."

Sixth District

William A. Dodd, M.D., of Wrightsville has been elected founding president of the American Health Care Medical Directors Association (AHCMDA). He was installed June 15 at Hilton Head, S.C., by James J. Pattee, M.D., who represented the AMA. AHCMDA is an association comprised of medical directors from health care facilities across the country. A non-profit organization, its purpose is "to improve health care for the convalescent and chronically ill of all ages."

Seventh District

Floyd Medical Center in Rome has elected officers for the coming year. They are: **Harlan Starr, M.D.,** President, succeeding **Charles Sennett, M.D.; James Routledge,** President-Elect; **L. C. Rigas, M.D.,** Secretary.

New officers for the Redmond Park Hospital staff: **Robert Farrell, M.D.,** President; **Joel Todino, M.D.,** President-Elect; **Leeon Rhodes, M.D.,** Secretary-Treasurer.

Robert T. Connor, M.D., of Rome, has completed continuing education requirements to retain active membership in the American Academy of Family Physicians.

Fellowships in the American Association of Cosmetic Surgeons have been granted to **Hamilton S. Dixon, M.D.** and **Tody S. Morgan, M.D.,** both of Rome.

DEATHS

John M. Anderson

Atlanta psychiatrist John M. Anderson, M.D., died June 30 at the age of 64.

Dr. Anderson, who had been practicing in Atlanta since 1953, was Assistant Professor in the Department of Psychiatry at Emory University School of Medicine from 1974 until his death. He was also a life fellow of American Psychiatric Association.

He is survived by his wife, Christine Rountree Anderson, two daughters, two sons and a sister.

William Osler Bedingfield

The 1959 President of the Georgia Medical Society, William Osler Bedingfield, M.D., died June 24 at the age of 72.

After graduating from the University of Georgia Medical School, Dr. Bedingfield did his internship at Candler General Hospital in Savannah, became the hospital's first internist, and later served as its Chief of Staff.

He was a fellow of the American College of Surgeons and a member of the Southeast Surgical Congress. He was also on the staffs of St. Joseph's, Memorial Medical Center and Candler Memorial Hospitals. During World

War II, he served as a medical officer.

Survivors include his wife, Carolina Marvin Bedingfield, a daughter, two sons, four sisters, two brothers and ten grandchildren.

Stewart McLendon Long

Stewart McLendon Long, M.D., 55, died June 28. A native Atlantan, he was on the staffs of Piedmont, Georgia Baptist and Crawford W. Long Memorial Hospitals and was on the teaching staff at Emory University School of Medicine.

Dr. Long was a member of the American College of Surgeons and the American Board of Surgeons. A graduate of Tulane Medical School, he served in the Army Medical Corp during the Korean War.

Survivors include his wife, Juanita Hewell Long, two sons, his mother, a sister and a brother.

Earl Atkinson Mayo Jr.

Founder of the Mayo Clinic in Richland (now the Stewart-Webster Clinic), Earl Atkinson Mayo Jr., M.D., died June 14 at the age of 54.

A native of Richland, he was a member of the staff of Stewart-Webster Hospital, was a former President of the Stewart-Randolph-Terrell Medical Society and was appointed to the State Medical Board of Examiners in 1964.

Dr. Mayo is survive by his wife, Joyce Joffrion Mayo, four daughters, a son, three sisters, a brother and three grandchildren.

Willis T. McCurdy

Stone Mountain physician Willis T. McCurdy, M.D., died July 6 at the age of 70.

A graduate of the University of Georgia Medical School, Dr. McCurdy did his internship at Emory University and Grady Hospitals. He was a retired Family Practitioner.

Survivors include his wife, Alice Horton McCurdy, a daughter, a son, four sisters and a brother.

Paul Leland Reith

Chief of Staff of the Warm Springs Foundation Hospital, Paul Leland Reith, M.D., 65, died July 2.

A graduate of Indiana University Medical School, Dr. Reith served as Chief of the Orthopedic and Fracture Service at Emory University, 1946-1952. He was a U.S. Army Major during World War II and served as Director of Surgery for Warm Springs Foundation Hospital from 1955 until he became Chief of Staff. He was a diplomate in the American Academy of Orthopedic Surgeons and a fellow of the American Academy of Surgeons.

Dr. Reith is survived by four daughters, including Paula Reith, an employee of the Medical Association of Georgia, one brother and four grandchildren.

Humberto Rodriguez

Valdosta physician Humberto Rodriguez, M.D., died June 23, a victim of drowning, at the age of 49.

Dr. Rodriguez, who was born in Cuba, had been practicing in Valdosta since 1972 and had practiced in Adel for eight years before that

He is survived by his wife, Clara Guzman, a daughter, two sons, his parents and two brothers.

DOCTOR, LAWYER
INDIAN CHIEF

Whatever your profession let us assist in making your home, office (or teepee) a perfect reflection of your taste and needs.

River Interiors is a professional interior design firm with exciting ideas plus practical know-how.

Do you want to spruce your space up a bit? Start fresh from scratch? Or want a new look using pieces you already have? River Interiors can do it with distinction and within your budget.

Interior design improvements are very personal. So we will make house calls to discuss your particular needs----- one professional to another. Consultation without obligation.

Call now for an appointment: 434-0828.

River
interior design

Smyrna, Georgia.

INCOME
PROPERTY
INSURANCE

You can reduce your insurance cost and have quality protection. We also offer estate planning, malpractice and personal insurance coverage.

Call:

JOHN LUSK
Insurance Agents, Inc.
Two Northside 75
Atlanta, Ga. 30318
(404) 351-8434

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone
Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

MEDICAL COORDINATOR. Must be recently active in practice of medicine, have current Georgia license as MD or DO or be eligible for Georgia license. Administrative experience desirable. Salary negotiable. Application to include curriculum vitae and resume to Composite State Board of Medical Examiners, Attention: Medical Coordinator Recruitment, 166 Pryor St., SW, Atlanta, Ga. 30303.

WILL SELL, IN WHOLE OR PART, 95 acres farmland, West Cobb County near MacLand; 25-29% down, balance on any reasonable terms. Write: Physician, P.O. Box 54778, Atlanta, Ga. 30308.

INTERESTED IN OTHER STATE MEDICAL JOURNALS? The Journal office has a collection of 1976 state medical journals from all over the country. If you'd like them, or know someone who could put them to good use, contact Sharon Smith at MAG headquarters, 938 Peachtree St., NE, Atlanta, Ga. 30309. Phone: (404) 876-7535 or toll free (in Georgia) 1-800-282-0224.

GP—WANT MORE Free time? Approaching retirement? I've got an idea! Share practice in perfect location with new, fully-equipped office, including lab and X ray. No in-patient care. Work Thursday, Friday, Saturday, Monday, Tuesday and Wednesday; then be off one week. Nothing to buy. North metro Atlanta location. Please send resume to Box 5-1, c/o the *Journal*.

Got a knack for public speaking? Or maybe a creative writing ability?

MAG needs volunteers to write and deliver speeches for a Speakers Bureau (see Editorial Page, March 1977). If you are interested in helping to spread the truth about rising health costs and other topics of importance, call MAG Headquarters at **(404) 876-7535; INWATS (800) 282-0224.**



Welcome to the 12-month summer

A Sun/Fun enclosed pool stops the calendar at summertime. It makes the climate you want, when you want it.

With a Sun/Fun enclosed pool you can enjoy swimming all year long, day or night, any weather.

You can have more family fun, enjoy spur-of-the-moment parties, get the benefits of invigorating, healthful exercise.

Sun/Fun keeps out rain, sand, wind, insects—makes your pool a year 'round, indoor-outdoor playground for all the family.

Welcome to the 12-Month Summer!

Find out more about enclosing your present or your planned pool. Contact

SUN/FUN POOL ENCLOSURES BY

AQUA-RAMA

Complete Engineering
And Design Service
Commercial & Residential

Dealer Inquires Invited

Pools & Patio Furnishings
565 Powder Springs St.,
Marietta, Ga. 30064
Phone (404) 422-6291
Visit Our Display.
Write or Phone For Brochure

One copy of the 1977 Roster accompanies this issue of the **Journal** for each active member of the Medical Association.

This valuable publication lists: MAG officers; committees of the Association and their membership; Auxiliary officers and their addresses; district, county medical society and specialty society officers; MAG members and their addresses, both in alphabetical order and by county medical society.

Additional copies of the roster for use at home or in a second office are available to members for $5 a copy. Non-member price is $10 for the first and every additional copy.

Checks should be made payable to the Medical Association of Georgia. Rosters will be mailed within two weeks of receipt of check.

1977 ROSTER ORDER FORM

Medical Association of Georgia

938 Peachtree Street, N.E.

Atlanta, Georgia 30309

Att.: Sharon Smith

MEMBERS ONLY: $5 (for second and above copies)

Enclosed is $..... for ..... rosters

NON-MEMBERS: $10 per copy

Enclosed is $..... for ..... rosters

Name: .....

Address: .....

.....

City **State** **Zip**



THE PERFECT GET-AWAY PLACE FOR YOU, YOUR FAMILY, YOUR COMPANY.

MOUNTAIN VIEW CONDOMINIUM VILLAS

Lake Arrowhead announces their brand new Mountain View Condominium Villas. These new Lake Arrowhead Condominiums are the most beautiful to be found anywhere—

- Rustic exterior design
- Central heat and airconditioning
- Fully equipped electric kitchen
- Washer/Dryer included
- Wood burning fireplace
- Wall to wall carpeting
- 2-1/2 baths
- Ample inside and outside storage
- Spacious sun deck
- Spectacular mountain view

Prices begin at $46,900

And here's more for you, after a nominal monthly maintenance charge and reasonable amenity fees!

- Membership in the Lake Arrowhead Country Club
- Championship 18 hole golf course
- Tennis and Swim Club
- 500 acre lake perfect for water sports and fishing
- Riding stables and mountain trails
- Picnic and recreational areas

For complete information and or personal inspection appointment call:

Lake Arrowhead Atlanta Office 266-1002

Or use this handy coupon.

Directions: From I-285 to U.S. 19 through Roswell to GA. 140. Once on GA. 140, follow the signs.

From I-75 go north to Roberts Road exit, then right to State Hwy. 5 to Canton, then north (left) on Hwy. 140 thru Waleska and follow the sign to Lake Arrowhead.

Lake Arrowhead is only 56 miles from Atlanta, 43 miles from Rome, 38 miles from Marietta, 21 miles from Cartersville, and 12 miles from Canton.



Yes, I am interested in learning more about Lake Arrowhead's brand new Mountain View Condominium Villas.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

Lake Arrowhead

56 miles north of Atlanta...where a sound opportunity awaits you.

Another ❮❯ Diamondhead Corporation Community

THIS AD DOES NOT CONSTITUTE AN OFFER TO SELL IN ANY STATE WHERE SUCH AN OFFER IS PROHIBITED.

Index to Advertising

Vol. 66 August 1977 No. 8

Aqua-Rama 667
Walter Ballard Optical Company 623
Brawner Hospital, Inc. 594
Bugatti Restaurant 615
Burroughs Wellcome Co. 647, 648, 649
Capital Automobile Company 664
Classified Advertising 667
Dickey-Mangham Company 666
Dorsey Laboratories 601, 602
Duluth Professional Park 593
Eager and Simpson 666
Faf Motorcars, Inc. 658
French Restaurant, The 615
Georgia Army National Guard 624
The Harrison Company, Publishers 643
Hickman Datsun 613
Hill Crest Hospital 632
Lake Arrowhead 605, 669
Lakeview General Hospital 623
Eli Lilly and Company 598
Lusk, John, Insurance Agency 665
MAGNET Conference 630
MAG Services, Inc. 646
Max' Restaurant 615
Metropolitan Psychiatric Hospital 652, 653
Mimi's Restaurant 615
Omni International Hotel 615
Parke, Davis and Company 596
Peachtree and Parkwood Hospitals 606
Pennwalt Prescription Products 660, 661
Pharmaceutical Manufacturers Association 650, 651
Physicians Registry 613
Potter-Holden & Company 597
Practice Productivity, Inc. 658
Preferred Partnerships, Inc. 662
Qualicare, Inc. 623
River Interiors 665
Roche Laboratories 592, 620, 621, 671, 672
Roerig 619
Roster of the Medical Association of Georgia 668
Scott Hudgens Properties 593
Smith, Kline & French 622
Terrace Garden Inn 631
United States Navy 664
Valley Psychiatric Hospital 666
Weight Watchers of Greater Atlanta 597
Willingway Hospital 641
Woodward Academy 597
1977 MAG Scientific Assembly 614

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.;* severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC

Since its discovery in the research laboratories at Roche, Libri has been the object of ongoing pharmacologic and clinical investigatio

The published record on Librium is enormous. So large, in fact, put it into a computer literature retrieval system to make it more accessil in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® IV
chlordiazepoxide HCl/Roche



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

JOURNAL
of the medical association of
georgia
SEPTEMBER
1977

MAGNET '77

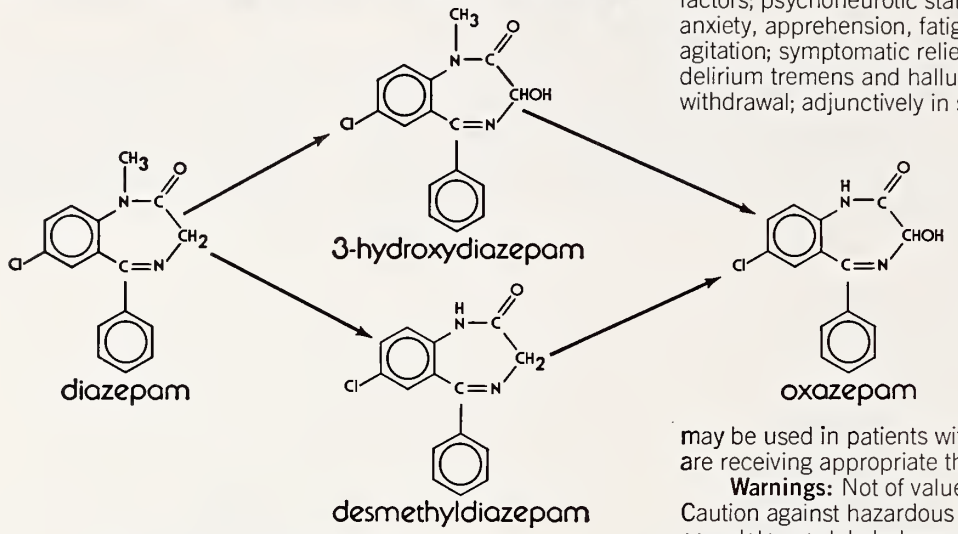
IS THIS THE ANSWER?

TERRACE GARDEN INN
OCTOBER 22-23
ATLANTA

LIBRARY
U.C. SAN FRANCISCO
OCT 13 1977

1977 MAG Scientific Assembly—November 17-20—Atlanta

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

This is not a solicitation or an offer to sell or buy any securities. Such an offer is made by prospectus only.

Preferred Partnerships inc.



Re: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Sir;

How much income tax are you now paying? We can help you shelter a portion of your present income --- plus show you how you can receive a Tax-Free return.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that gives you a better tax write-off. We have investments in the $5,000-$8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

Brawner Hospital, Inc.

Established in 1910
3180 Atlanta Rd.
Smyrna, Ga. 30080
(404) 436-0081



Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of
georgia

contents

VOLUME 66, NUMBER 9

EDITOR
Edgar Woody Jr., M.D.
MANAGING EDITOR
Sharon T. Smith
BUSINESS MANAGER
L. B. Storey
ADVERTISING REPRESENTATIVE
Mary Coté
CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta
PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House
THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
Adam R. Jablonowski, Assistant Executive Director—Medical Practice
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Charles Templeton, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant to the Executive Director

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.
Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

698 A Method of Hernia Repair
Sidney Appel, M.D.
703 Group B Streptococcal Infections in the Neonate
William Lee Tift, M.D.

SPECIAL ARTICLES

681 The Future of Small Hospital Libraries
Nicholas E. Davies, M.D.
689 Contraceptive Usage and Other Characteristics of 440 Pregnant Teenage Patients at MCG in 1975
Virginia McNamara, M.D.
W. A. Scoggin, M.D.
713 National Health Insurance
James H. Sullivan, M.D.

EDITORIALS

719 MAGNET 77—Is This the Answer?
Marvyn D. Cohen, M.D.

FEATURES

725 President's Letter/HSAs: Danger Lies Ahead
Robert E. Perry Jr., M.D.
727 I've Told This Before/How to Give Your Wife a Pep Shot Without a Needle
J. G. McDaniel, M.D.
729 Cancer Page/Recent Developments in Cancer Chemotherapy
Stanley Winokur, M.D.
737 Heart Page/New Format: Your Participation Is Requested
Robert M. Patton, M.D.
739 Legal Page/Informed Consent—Georgia Update
J. Winston Huff

THE ASSOCIATION

743 New Members
743 Personals
743 Deaths

NEWS

683 Workshop on Hospital Libraries
684 Scientific Assembly Registration Form
708 Journal Advertisers
715 MAGNET 77 Program and Registration Form
720 Guest Educators in Various Specialties to Address Scientific Assembly
730 Cobb Society Sponsors Mini-Symposium
730 National Medical Seminars
741 Medical Meeting Calendar

THE COVER

MAGNET 77 promises to provide physicians and their business managers with plenty of practical ideas on improving the business aspects of a medical practice. For more information on this exciting event, see pages 715 and 719 and contact the MAG office. Cover design by Bob Hamill, Atlanta.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
© WEIGHT WATCHERS INTERNATIONAL, 1977

NOW . . . CME RECORDKEEPING WITH COMPUTER ACCURACY AND CONVENIENCE!

The Physicians Registry brings computer accuracy and convenience to CME (Continuing Medical Education) recordkeeping. It's a complete service—*we* keep track of all your CME credits.

You'll receive everything you need. After participating in a CME activity, just fill in one of the brief, pre-printed cards the Physicians Registry provides and mail it to us.

Every three months, you'll receive a computer-generated summary of your credits. You'll also get annual reports summarizing all credits for the past three years.

Think of the confusion and wasted time you'll save. Of course, your records are completely confidential. And your periodic reports from the Physicians Registry can come in very handy at tax time.

The cost is a modest, *deductible* $50 per year. Over 1500 physicians have already enrolled in The Physicians Registry, and we have successfully recorded over 77,000 hours of CME credit.

You may spend up to $2,000 per year on CME activities. Why not spend $50 to keep your CME records efficiently?

Consider joining The Physicians Registry.

For more information, write:

Richard J. Ladon, Director

THE PHYSICIANS REGISTRY

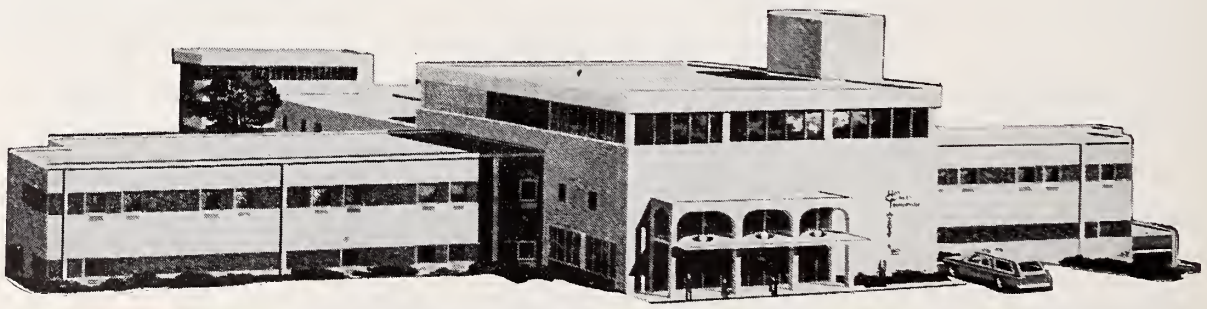
640 North LaSalle Street, Chicago, Illinois 60610
Or call us collect at (312) 368-1377

Hill Crest HOSPITAL

Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.

Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

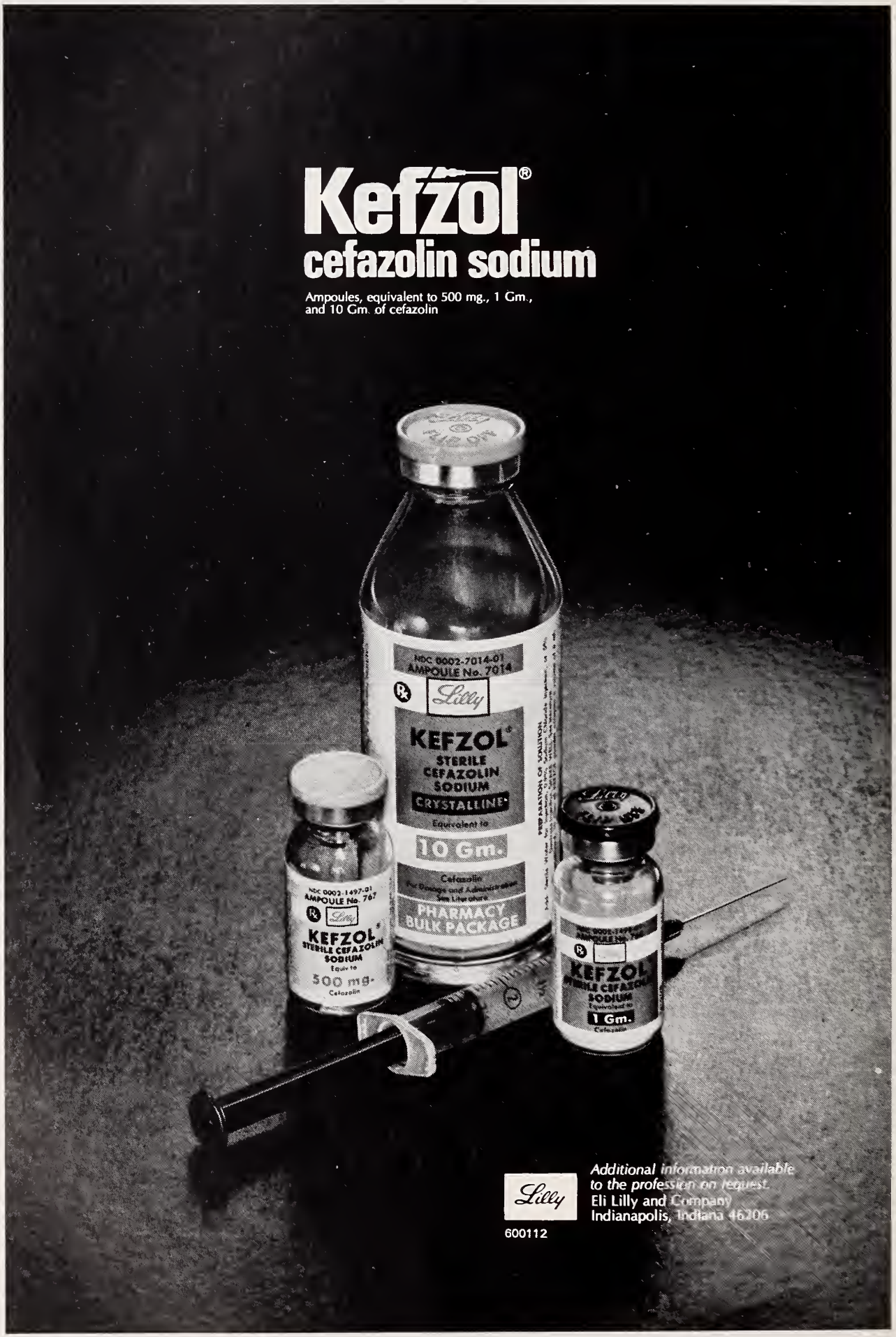
Physicians. Isn't it time your career had a check-up?



Of course, we don't mean to imply that your career isn't a healthy one. We just want to draw your attention to the personal and career opportunities and benefits the Air Force has to offer you. You'll discover that the Air Force is a challenging and rewarding way of life. Our hospitals and clinics are outstanding. Plus, we'll pay relocation expenses for your family and household goods. If you're interested in our medical plan, find out all the facts. Sometimes, even a healthy career could use a checkup.

Contact

Capt. Lohman D. Reiter
Suite 208
3050 Presidential Dr.
Atlanta, Ga. 30340
(404) 451-3888


Kefzol®
cefazolin sodium
Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
KEFZOL
STERILE
CEFAZOLIN
SODIUM
CRYSTALLINE
Equivalent to
10 Gm.
PHARMACY
BULK PACKAGE
KEFZOL
500 mg.
KEFZOL
1 Gm.
Lilly
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
600112

JOURNAL
of the medical association of
georgia

The Future of Small Hospital Libraries

NICHOLAS E. DAVIES, M.D., *Atlanta**

Red Clay Hospital Installs Computer Terminal

The computer terminal recently installed in the Information Center at Red Clay Hospital has helped internist Joseph Taylor make the first diagnosis of mucormycosis ever proven in the Red Clay-Peanut City area of Middle Georgia. Taylor found a lesion in a patient in diabetic ketoacidosis, entered the patient's history, physical and laboratory data into the Diagnostic Assistance Program of the computer, and had this diagnosis suggested. The computer inquired about diagnostic tests which, when carried out in the hospital laboratory, confirmed the presence of Mucorales. The patient is now recovering at the Medical College of Georgia where she is being treated with ST 37, a recently discovered antifungal agent.

The new diagnostic and therapeutic programs offered by the National Medical Information Service (a division of DHEW, three universities and a medical foundation) were developed during the past decade in several medical centers about the country. Now that the costs for the hardware have decreased significantly, terminals are being installed in most hospital libraries. According to Dr. Taylor, the terminals allow him access, both diagnostically and therapeutically, to the best medical brains in the country almost instantaneously. He regards the computer as the greatest diagnostic aid since the discovery of x-ray—**Journal of the Medical Association of Georgia,** *Vol. 79, July, 1990.*

TOMORROW'S INFORMATION centers are today's hospital libraries. Many small hospitals in the United States are forming their own libraries with collections of books and journals and with systems for retrieving up-to-date information from larger hospitals and regional centers. Other small hospitals are developing consortia with neighboring institutions (other hospitals, community colleges, public libraries, etc.) to establish core libraries and retrieval systems of higher quality than would be financially available to each separately.

The Small Hospital Library Project of the Medical Association of Georgia hopes to see a library/information center in every hospital in the state within the next decade. "Impossible," you say. Perhaps,

It may not be what you think . . .

but the need is there. The rapid availability of accurate information should be even more important to a small rural hospital than it is to a larger urban hospital. The reason is obvious: to practice good medicine, family physicians in rural settings must have a vast array of information available quickly and easily. Specialists and subspecialists are not so readily available to them as they are to physicians in urban areas. Except in Alabama, where the Medical Information System by Telephone (MIST) is operating, most physicians in rural areas do not have easy access to all specialties.

Sadly, as is so often the case, those with the greatest information needs have the least information available to them. Hospital libraries in the past have often been considered "erudition centers." Hospital administrators, following the mandates of penurious hospital trustees, have long considered hospital libraries as ornaments of culture rather than practical instruments to implement high quality medical care. (1) Physicians practicing in these hospitals have done little to change the situation because they

* Chairman, Small Hospital Library Project, Medical Association of Georgia. Dr. Davies' address is 35 Collier Rd., Suite 650, Atlanta, Ga. 30309.

have not been trained to use modern information retrieval systems. Indeed, many do not know that these systems exist.

Besides information retrieval, modern hospital libraries have many other functions. Consider, for example, the continuing education of physicians. How can good education programs be presented to every physician in every hospital in Georgia? The answer, of course, is that they cannot. Only the largest hospitals and those near teaching centers can offer high quality programs on a regular basis. Additionally, medical programs in small hospitals must be of a general nature to appeal to the family physician, the surgeon, the radiologist, and perhaps one or two other specialties.

The best answer to the problem of continuing medical education in small hospitals at this time is a combination of interesting and pertinent video tapes, audio cassettes and slide-tape learning programs. These should supplement the physician's reading of articles (provided quickly by his local librarian/information specialist) relevant to problems that he faces daily in his practice.

Patient education is becoming increasingly important. In many hospitals the library is the patient education center where nurses, dieticians, and others instruct patients and their families in such things as diabetic care, diets, back exercises, cardiovascular risk factors, and hypertension medications. Third-party payers are accepting reasonable charges for these educational programs on the premise that it is better to teach a diabetic, for example, about his disease than to continue to pay for the complications of his mismanagement.

Hospital libraries support nursing education, in-service education programs and sometimes the administrative staff. Many hospital libraries supply patients and their families and friends with reading material both for entertainment and educational purposes. Because of the many functions of hospital libraries, they are now known as "health science libraries" rather than "medical libraries."

Computer Information Programs

Most physicians are not aware of the remarkable development of computer programs for the diagnosis and treatment of complex diseases. One such program is being produced by Dr. Jack D. Myers and associates at the University of Pittsburgh Medical School. Dr. Eugene Stead is developing a complex computer program on myocardial infarctions at Duke University. Another is under way at Stanford University.

In November, 1976, at the American College of Physicians meeting in Atlanta, Dr. Myers described the program he is developing. He presented two patients with complex disease problems who had been diagnosed accurately and quickly by computer. The program is capable of arranging disorganized information and using it to make multiple diagnoses in a single patient. It not only asks for specific information, it asks for it in such a way as to suggest cheap and safe tests before asking for expensive and potentially dangerous ones. Ultimately, it will be able to diagnose over 1,000 conditions seen by general internists.

Diagnostic and therapeutic computer programs will undoubtedly be a boon to medical care in the future. As programs are developed, medical students will be taught to use them like pocket calculators, and their cost will become acceptable as subscribers increase. The computer terminals will most likely be in the hospital library. In time they may be in physicians' offices. There will be cheap, rapid transmission of all sorts of information over these same terminals, so that any given article in print will be available to the physician who has access to the terminal. In the next decade or so, vast stores of medical information will be almost instantly available for those prepared to receive it.

Today's hospital library is tomorrow's hospital information center.

Southeastern Regional Medical Library Program

The Regional Medical Library network was created a number of years ago by the National Library of Medicine to assist all health practitioners (doctors, nurses, technicians, researchers, educators and students) with their information needs. Their ultimate goal, as is that of all of us in the health field, is to improve the well-being of our citizens. For medicine specifically, the goal is to improve patient care. The plinth of this regional network is the community hospital library and the library in other local health science facilities, called the "basic units" of the Regional Medical Library Program. At the next levels of the network are Resource Libraries and Regional Medical Libraries, usually located in medical schools, which provide the basic units with literature and services not available locally. The National Library of Medicine in Bethesda serves as the backup resource for the entire network.

The hospitals and physicians of Georgia are fortunate to have the headquarters for the Southeastern Regional Medical Library Program (SERMLP) in the Abner Wellborn Calhoun Library at Emory University. Emory's Medical Librarian, Miriam Lib-

bey, is Director of SERMLP; the Assistant Director is Michael Torrente. With other members of their staff and with Thomas Basler, Director of Libraries at the Medical College of Georgia in Augusta, they have been increasingly interested in helping hospitals, both large and small, develop and improve their libraries. They have advised the Small Hospital Library Project of the MAG; they have assisted small hospitals individually; they have encouraged the formation of the Atlanta Health Science Libraries Consortium and the formation of a statewide health sciences library association.

In order to promote more and better "basic units," the National Library of Medicine announced in November 1976, the availability of funds in the form of grants which allow up to $4,000 for the first year to organize a consortium and up to $3,000 the second year for each institution on a matching fund basis of $3 grant funding for every $1 provided by the hospital. This money can be used to purchase books, journals and audiovisual programs. A consortium may be composed of hospitals (large or small), mental health centers, community colleges, research facilities, public libraries, or any combination of these, so long as the consortium focuses on services for health personnel.

Briefly, a small hospital library consortium usually begins when a person, often a physician but sometimes a nurse or other hospital employee, becomes frustrated with his or her inability to find needed information quickly. An example will help to illustrate this. The daughter of the mayor of a small Georgia town marries a young man with von Willebrand's Disease. The new husband visits the family's physician and explains in rather sophisticated terms his coagulation problem. The physician can find little in his textbooks about von Willebrand's Disease and his access to a hematologist is limited. What can he do? Must he wait until he visits a larger city with a medical library to research the problem? Must he tell the young man that he is incapable of taking care of him? Or should he simply pray that the patient will not bleed before he can find out the modern emergency treatment for patients with this rare condition?

The definitive solution for this problem would be to establish a small, inexpensive collection of books and journals in the community hospital under the supervision of a person who had learned to retrieve information in a hurry. To lessen the cost and to widen the scope of the information available, several institutions in physical proximity could join together to share resources. A consortium is born!

During the past several months, SERMLP has sponsored consortia development workshops in Chattanooga, Tennessee and Charleston, South Carolina. At the latter, there were representatives of the following Georgia hospitals; Memorial Hospital, Bainbridge; Tift General Hospital, Tifton; Tanner Memorial Hospital, Carrollton; Candler General Hospital, Savannah; and Georgia Regional Hospital, Savannah. In Chattanooga there were no representatives of Georgia hospitals. Perhaps they were not represented because the workshop was not well advertised. Perhaps our hospitals did not understand the importance of the program to them. Parenthetically, besides Consortia Development workshops, SERMLP has developed a workshop for Basic Library Services and Organization for the Small Health Sciences Library and one for Management of Audiovisuals for the Small Health Science Library. Any one or all of these workshops can be given in Georgia if there is sufficient interest.

The information gap between large medical centers and community hospitals, especially small community hospitals is widening. In the future, computerized hospital information centers can do a great deal to narrow this gap. Physicians need to understand this. Hospital administrators and trustees need to understand this also, for it is upon them that the ultimate responsibility lies for providing excellent care in their hospitals (and, to an extent, in their

Workshop on Hospital Libraries

"Basic Library Services and Organization for the Small Health Science Library" is the subject of a November workshop to be conducted by the Southeastern Regional Medical Library Program (SERMLP) in cooperation with the Georgia Health Sciences Library Association. Designed especially for hospital personnel who have had no formal education in librarianship, the workshop will be held at the Northlake Hilton Inn in Atlanta on November 8-10. Participants are also invited to attend the meeting of the Georgia Health Sciences Library Association on November 11.

The MAG Committee on Education actively supports the improvement of libraries in smaller hospitals through the training of hospital personnel who would work at least part-time as librarians. It is envisioned that such hospital libraries could become centers of continuing medical education where regular accredited CME programs are not available locally.

Registration fee for the workshop is $10.00. Participants pay for their own travel, food, and lodging. For further information, contact Miriam Libbey, A. W. Calhoun Medical Library, Emory University School of Medicine, Atlanta, Georgia 30322 (TEL: 404/329-5820).

communities). It is the responsibility of physicians and nurses to keep their administrators and trustees (as well as themselves) informed about health care progress.

Conclusions

As the information gap widens between medical centers and community hospitals, hospital libraries become more important to physicians and others who are concerned with the rapid growth of medical information and the new methods that are being developed to disseminate it. As our citizens become more sophisticated medically, they expect better care for themselves and their families.

Rapid information is now available to even the smallest of hospital libraries. The staff of the Southeastern Regional Medical Library Program, headquartered at Emory, is eager to help anyone who is interested in the subject and who is willing to devote a little time and money to developing their own library consortium. Limited funds are available from the National Library of Medicine for this purpose. The staff at SERMLP will help prepare grant applications and will help with alternative plans if grant funds are not obtained.

Today's hospital library is tomorrow's hospital information center. Today's hospital library supports the practice of good medicine, but tomorrow's information center, with its sophisticated retrieval systems, with its computerized diagnostic and therapeutic programs, and with other as yet uninvented programs, will be essential. We need to begin now.

"Computer programs will undoubtedly be a boon to medical care in the future . . . medical students will be taught to use them like pocket calculators."

The author gratefully acknowledges the assistance of Mrs. Miriam Libbey in preparing this paper.

REFERENCE

1. West, K. M.: "Library and Information Services for Small Hospitals," *JAMA* 232:505-508, 1975.

MEDICAL ASSOCIATION of GEORGIA
Education Division

REGISTRATION FORM

1977 MAG SCIENTIFIC ASSEMBLY **November 17-20, Omni International Hotel, Atlanta**

NAME:_____

ADDRESS: _____

_____

Please check appropriate boxes:

Registration Fee and Tickets

☐ Member, Medical Association of Georgia	$15.00
☐ Visiting Physician	25.00
☐ Intern or Resident	(no fee)
☐ Physician Assistant, Allied Health Professional, or Nurse	10.00
☐ Interdisciplinary Workshop on Asthma, Thursday (includes lunch ticket)	15.00
☐ MAG Luncheon, Friday Number attending _____ Tickets:	8.00 each
☐ GSIM Luncheon, Saturday Open to all Physicians and Spouses Number attending _____ Tickets:	10.00 each

To order slides for Pediatric Pathology Seminar:

☐ Slides only	25.00
☐ Slides for registered participants (slides will be mailed in advance of meeting)	15.00

Enclosed is my check to the Medical Association of Georgia for _____

Important: (Please check appropriate boxes)

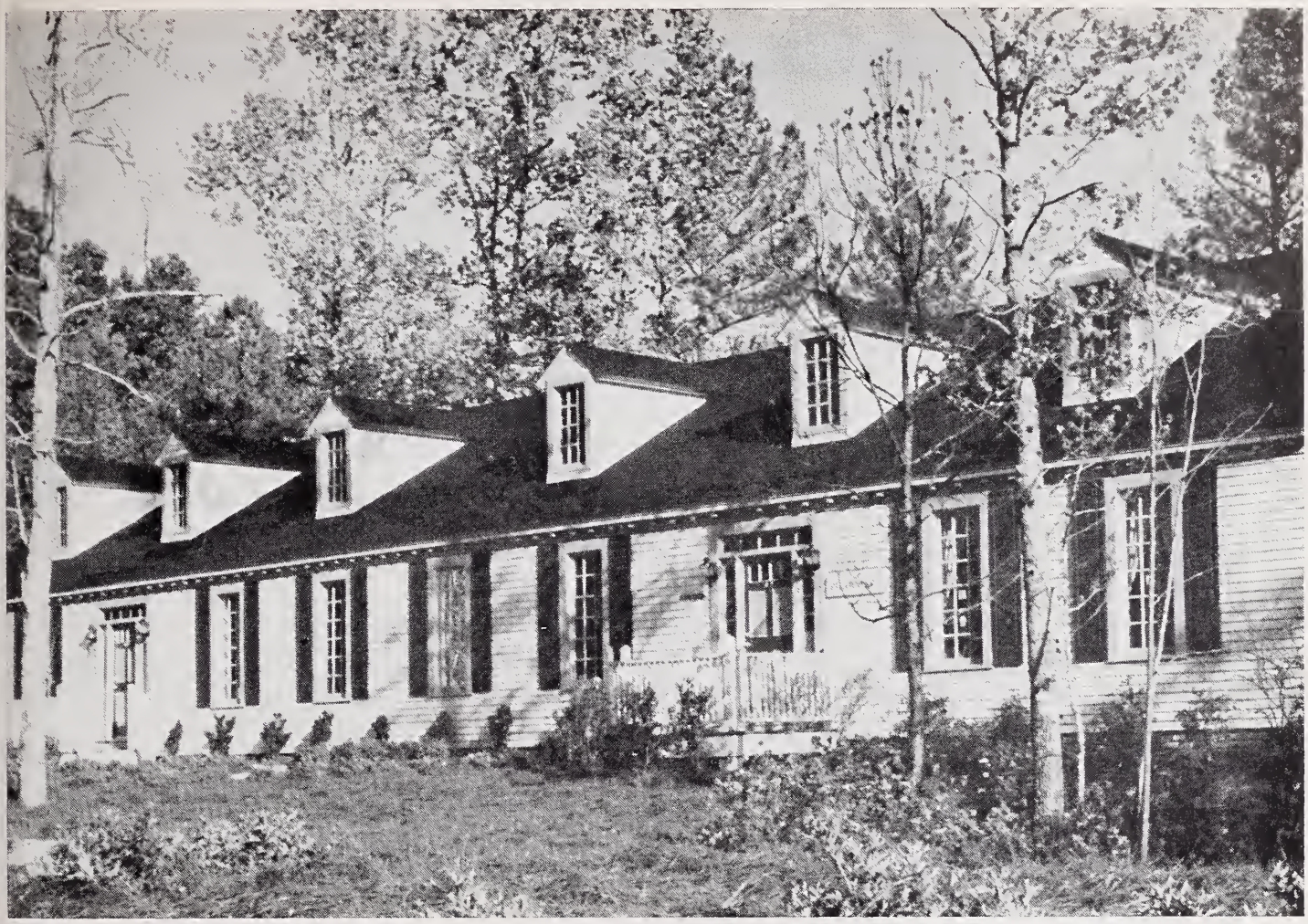
I plan to attend the Scientific program(s) sponsored by

- ☐ Allergy and Immunology Society of Georgia
- ☐ American Academy of Pediatrics, Georgia Chapter
- ☐ American Association of Public Health Physicians, Georgia Chapte
- ☐ American College of Emergency Physicians, Georgia Chapter
- ☐ American College of Physicians — Georgia
- ☐ American College of Surgeons, Georgia Chapter
- ☐ Georgia Gastroenterologic Society
- ☐ Georgia Health Care Medical Directors Association
- ☐ **Georgia Lung Association, etc. (Interdisciplinary Asthma Workshop**
- ☐ Georgia Neurological Society
- ☐ Georgia Neurosurgical Society
- ☐ Georgia Psychiatric Association
- ☐ Georgia Radiological Society
- ☐ Georgia Society of Internal Medicine
- ☐ Georgia Society of Ophthalmology
- ☐ Georgia Society of Pathologists
- ☐ Georgia Society of Plastic Surgery
- ☐ Georgia Thoracic Society

MAG will help you coordinate your personal CME program — Phone (404) 876-7535 or WATS 800-282-0224

Clip and Mail to: MAG Scientific Assembly
938 Peachtree Street, N. E.
Atlanta, Georgia 30309

So near and yet so far away is not a contradiction.



Scott Hudgens Properties

Duluth Professional Park

IN GROWING GWINNETT COUNTY—A BEAUTIFUL OFFICE COMPLEX WITHIN A 1500-ACRE PLANNED UNIT DEVELOPMENT.

So near . . . Joan Glancy Memorial Hospital . . . Atlanta Athletic Club . . . major Northside corridors leading to metropolitan Atlanta . . . a growing community.

And yet so far away . . . from the hustle and bustle of the city. Each Williamsburg designed building has private entrances for staff and doctors . . . plenty of parking . . . plenty of peace and quiet.

All new buildings . . . all are ground level. Competitive rates and custom-designed interiors make this a superlative opportunity.

Howell Station
ON THE RIVER

Contact
Dan Arnold
P.O. Box 988
Duluth, Ga. 30136
(404) 964-1351

Estes Surgical Supply Company

—SINCE 1908—

EXAMINATION FURNITURE
OFFICE FURNITURE
LAB SUPPLIES
ELECTROCARDIOGRAPHS
PHYSIOTHERAPY APPARATUS
SURGICAL SUPPLIES & INSTRUMENTS
SUNDRIES
X-RAY SUPPLIES
COMPLETE OSTOMY LINE

351-2011
890 CHATTAHOOCHEE AVE., NW
(NEAR I-285 & I-75 N.)

Practice where the big premium is on medical care.

Not on high overhead. Or paperwork. Or any of the other hassles that keep chipping away at your clinical time.

If you want more out of your medical career, consider what the Navy can offer. A ready-made practice where patients' medical care is independent of the fluctuations of the economy. An engaging life-style. Adventure. Travel. And as much as $30,000 to $40,000 a year to start.

This year the Navy needs General Practitioners for the Flight Surgeon program, for Undersea Medicine, and as General Medical Officers. We also need specialists in Anesthesiology, Family Practice, Psychiatry, Internal Medicine, Neurology, Radiology, Pathology, and Pediatrics. If your interests lie in any of these clinical areas, and you'd like to get back to pure medicine, the Navy is for you. Get all the facts from your local Navy medical recruiter.

Fewer than 200 physicians are needed, so don't delay.

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017



When you're good people recognize you.

Highly effective
Single-dose convenience
Non-staining
Economical
Pleasant tasting

Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION

a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

©1977 LONE RANGER T.V., INC.



BREATHING WITH COMFORT.

Choledyl – a highly soluble, true salt of theophylline – rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. *Indications.* Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. *Warning.* Use in pregnancy – animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. *Precautions.* Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. *Adverse Reactions.* Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. *Dosage.* Average adult dosage: Tablets – 200 mg, 4 times a day; Elixir – two teaspoonfuls, 4 times a day. *Supplied.* 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose – 200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir – bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). *Toxicity.* Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C

WARNER/CHILCOTT
Division Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL®
(OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

Teenage pregnancy is one of the most baffling social and economic problems of today.

Contraceptive Usage and Other Characteristics of 440 Pregnant Teenage Patients at MCG in 1975

VIRGINIA MCNAMARA, M.D., *and* W. A. SCOGGIN, M.D., *Augusta**

THIS REPORT IS MADE to delineate contraceptive usage and other characteristics of teenage girls from the East Central Health District who received obstetrical care at the Medical College of Georgia, Department of Obstetrics, during the period January 1, 1975-December 31, 1975. Through the Maternity and Infant Care Project, every obstetrical patient from the 13 rural counties surrounding Richmond County receives not only quality obstetrical, medical and nursing care, but educational, nutritional and social work services as well.

Traditionally, during the several months that these patients are enrolled in the service, there is no difference in the services offered the mature woman and the teenager. Specifically, there is no program tailored to the needs of the adolescent patients. In the outpatient clinic and on the delivery floor on any day of the year, the excessively large number of adolescent patients is visible to the most casual observer. Unfortunately, this situation is not of recent development.

There are many reports in the medical literature that describe the obstetrical, psychological, educational and developmental hazards for the gravid teenagers.[6] One of the classic reports was that of Dr. Philip Sarrel of Yale Medical Center.[4] At Yale, he was struck by the increasingly large number of pregnant girls who, after one pregnancy, continued to repeat pregnancies at frequent intervals with interruption of their educational progress and continuance on welfare dependency. In the year 1965, he had followed 100 teenagers for five years and in that period of time, all except five had repeated pregnancy to produce a total of 340 babies. Most of these young women dropped out of school, began or continued welfare dependency and consigned their lives to reproductivity rather than productivity. As a result of these alarming statistics, he began a program for the young pregnant women called Y-Med and was successful in preventing repeat pregnancies and rehabilitating these young women back into the mainstream of adolescent life. The success of this brilliant project (much followed as a model) was due to the many disciplines working in close cooperation to change the contraceptive practices and social values of these young women.

At the Medical College of Georgia, Department of Obstetrics and Gynecology, the Maternity and Infant Care nurses have as their chief function the teaching of anatomy, physiology of pregnancy and newborn care. A great deal of this instruction is devoted to the topic of birth control and the desirability of optimum child spacing for mothers' and family's health. The nurses keep a record on each patient and it is from this record that the data in this report were abstract-

* Dr. McNamara is Associate Professor and Dr. Scoggin is Professor and Chairman of the Department of Obstetrics and Gynecology, Medical College of Georgia, Augusta, Ga. 30902.

CHART I

PREGNANCIES AT MEDICAL COLLEGE OF GEORGIA FROM EAST CENTRAL HEALTH DISTRICT JAN. 1975-DEC. 1975

18 years and under	440
Over 18 years	678
Total	1,118

CHART II

PREGNANT ADOLESCENTS BY AGE

Years of Age	No.
18	146
17	102
16	100
15	59
14	24
13	2
12	2
11	1
Not stated	4

CHART III

OBSTETRICAL BASELINE TEENAGE PREGNANCY

Juvenile pregnancy	Prior to 13th birthday
Adolescent pregnancy	After 13th birthday Prior to 16th birthday
Late teenage pregnancy	After 16th birthday Before 20th birthday

CHART IV

TEENAGE PREGNANCIES AT ETMH BY PERCENTAGE DR. HUFFMAN'S AGE GROUPING

Juvenile gravida (prior to 13th birthday)	7	1.2%
Adolescent gravida (after 13th birthday—before 16th)	85	19.5%
Late teenagers (16th birthday and over)	348	79.0%

CHART V

PREGNANT TEENAGERS BY PARITY

Pregnancy	
I	346
II	80
III	13
IV	0
V	1

ed. Those young women who had reached 18 at time of registration in the clinic and those under 18 were separated from the total number and it is this young age group that is the subject of this study.

Chart I shows that of 1,118 obstetrical patients delivered from the East Central Health District, 440 or 39 percent were to girls 18 years and under.

Chart II shows a breakdown by age from 11 to 18. Fortunately, the majority of these, 79 percent, fall in the 18-, 17- and 16-year-old group and for all obstetrical purposes can be expected, with good and regular care, to have about the same incidence of OB complications as the older women. This paper does not deal with the obstetrical complications in these young girls, for this has been repeatedly studied. It is of note that most of the data from such studies are not too helpful since every investigator has chosen a different age categorization and comparison from one group to another. Then too, socioeconomic factors are usually not included, though there is one good study that shows that complications in the young patient who is well nourished and comes regularly for prenatal care is not significantly different from that of the woman in the optimum childbearing age group.[5]

In reporting a study of pregnant teenagers, a writer is usually confounded by the lack of definition by specific age groups. As a consequence, leaders in adolescent gynecology are pleading for a consensus of specific age categorization in this population. Dr. John Huffman suggests that just as there is a consensus on the age definition for the "elderly primipara," so there should be agreement on the definition of the "adolescent gravida." He suggests the breakdown into age groups shown in Chart III.[2]

The age groups into which our patients fall suggest that by far the largest percentage of these have obstetrical outcomes much like those of their older sisters and other female relatives.

Dr. Huffman believes that young women 16, 17, 18 and 19 years of age are not adolescents from a biological and obstetrical viewpoint. He goes on to state, "the necessity for establishing definitive baselines is pertinent, not only as regards obstetrical performance, but also as regards treatment of the patient in the several age groups . . . it follows that the OB records of girls 16 and over should not be combined with those 16 and under."[2]

Chart V is probably the most significant and telling of the entire report. Three hundred forty six or 79 percent of these teenage pregnancies are first pregnancies. Though no specific age breakdown was done, in general the younger the girl, the more probable she is to fall into the Parity I group. Ninety-three (21 percent) are in their second or third pregnancy and one patient is having her fifth pregnancy! It is apparent from previous records that many of

these repeaters were our patients at the time of their first pregnancy. Many of the teenagers return to us again pregnant when only a few months postpartum. Unfortunately, this pattern persists for many girls. The para 5 of this study is 17 years old! Between pregnancies, she used *no* birth control. She is married and at time of her appearance at the OB Clinic, the nurses' record stated that her husband wants her to undergo tubal ligation so that she can return to work!

In the nurses' record, the question is asked of the young gravida, "Was this pregnancy planned?" As Chart VI shows, 361 pregnancies were unplanned, representing an astoundingly high 82 percent of the total teenage pregnancies.

Chart VII depicts the marital status of the young women. The records did not contain the questions that would have enabled us to learn whether or not pregnancy catapulted a girl into marriage or whether she became pregnant by planning after marriage. In general, it was observed that a few obtained married surnames during the course of their prenatal period. It is our impression that the young white girls seem to see pregnancy as very desirable immediately after marriage. This seems to stem from a social pressure in this society of young women. The extreme youth of the young married woman seemed to receive no consideration. It was of interest that in many of the very young women, marriage was to older men.

Chart VIII reveals planned pregnancies of the study subjects by marital status. That 43 married desired pregnancy may reflect the fact that pregnancy is seen as the hallmark of a "good marriage" by some elements of the population. The desirability of a year or so of marriage for the man and woman to become well acquainted and to have achieved a little more maturity in parenting appears to have gone without consideration.

Chart IX reveals a baffling fact, i.e., that of 440 girls in the study group, a little more than one half, or 224, were using *no birth control* and had *never* used any! The 69 girls who wanted to become pregnant would lower this number to 155, but even with this subtraction there remains an amazingly high percentage of one third using no contraception. About one-half of the population had attempted unsuccessfully to use some form of birth control.

Chart IX-A shows the pill to be first choice and the condom second. Only a small number chose the IUD.

Dr. Eugene C. Sandburg has listed and discussed 16 reasons for discontinuation of the birth control methodology.[3] On our nurses' record, there is an item that asks, "Contraceptive Failure?" Under this, a second item inquires, "Contraceptive Used?" Two hundred sixteen girls attempted to use birth control

CHART VI

PREGNANCIES PLANNED/UNPLANNED

Planned	69
Unplanned	361
Not stated	10
	440

CHART VII

MARITAL STATUS OF TEENAGE PREGNANT GIRLS—1975

Single	310
Married	127
Not stated	3
	440

CHART VIII

PLANNED PREGNANCIES OF 69 ADOLESCENTS BY MARTIAL STATUS

Single	26
Married	43

CHART IX

BIRTH CONTROL AMONG ADOLESCENTS

Number using no birth control	224
Number attempting some birth control	216

CHART IX-A

BIRTH CONTROL ATTEMPTED BY ADOLESCENTS

Pills	156
IUD	13
Condoms	33
Foam	3
Other	3
Not stated	8
	216

CHART X

POSTPARTUM VISITS TO ETMH BY 440 TEENAGERS

Postpartum visit to ETMH	366
Postpartum visit to LHD	44
Not stated	30

but failed to use it successfully for several reasons. The greatest number admitted failure in pill taking and over and over, the following reasons were given:

1. "They made me sick."
2. "They made me dizzy."
3. "I was nauseated."
4. "Bleeding or spotting bothered me."
5. "My period stopped or I missed some."
6. "I had headaches."
7. "I was depressed."
8. "I was afraid I would die."
9. "I gained weight."
10. "My legs hurt, my blood pressure went up."
11. "I forgot, I couldn't remember."

One girl felt so miserable that she decided to take an overdose to end her life. Fortunately, she was not successful. Occasionally, a young woman would report going off the pill because of side effects she reported to the M.D. Oddly, the implication seems to be that neither the patient nor the M.D. considered an alternate method!

Reasons for IUD failures are several. A few became pregnant with the IUD in place. Some requested removal and substituted no other method. There were several who had lost the IUD without knowing this til pregnancy ensued.

Failures on condoms and foam are small in number. As the pill is overwhelmingly the most popular choice of the teenager visiting the Family Planning Clinic, not many girls choose foam and condoms. Keeping a supply on hand may be a task these girls see as onerous. On talking to the girls, one gets the impression that when they do use this method, it is rather a sporadic and inconsistently used method. Dr. Robert Hatcher suggests that proper use of foam and condoms for the girl having infrequent sex may be met with a high degree of success if the girl and her sex partner really understand usage.[1]

It is recommended that special clinics for adolescents only be set up in Health Departments and that school systems include human sexuality and responsibility in their curriculum.

Chart X shows a good percentage of the young women returning for postpartum care and family planning so there is an opportunity to prescribe contraceptives and educate and help motivate young women to continue usage.

Chart XI shows the methods prescribed for the postpartum patients. The physicians and staff of other disciplines more and more are emphasizing the desirability of IUD (especially the Copper 7) as free of side effects and non-demanding of patient effort.

CHART XI

BIRTH CONTROL METHODOLOGY CHOSEN AT P.P. VISIT

Pill	258
IUD	83
Foam and condoms	6
Tubal ligations	1
Not recorded	18

CHART XII

WELFARE STATUS OF TEENAGE PREGNANT GIRLS

Receiving welfare at time of pregnancy	154
Receiving support from family or husband or other sources	268
Anticipating welfare to newborn	218
Support not known	20

Chart XII shows welfare dependency of this cohort of patients. As can be seen, many are on welfare and quite a large number will expect to get the AFDC welfare aid for their newborn. Those who are supported by families in many instances come from very low income families where the addition of an extra mouth to feed and living space become a problem. There are some women in this group who work and some are supported by husbands. These, of course, are not eligible for welfare aid to self and newborn except in rare instances of unemployment, disability, etc.

This report points out clearly that: (1) Far too many of the teenage population are *not* making use of the local Health Department contraceptive services available to them. (2) Of those who do make the initial visit to a resource for birth control, the education of the patient does not prepare her with the knowledge that certain side effects may be encountered that can probably be corrected if she will return to the clinic for follow-up.

In summary, it is recommended that special clinics "For Adolescents Only" be set up in Health Departments. Such clinics could offer a physical examination and a battery of screening and laboratory services. Referral services for such problems as adolescent acne, obesity, etc., would attract many teenagers. Teaching of self-breast examination and the desirability of annual Pap smear and pelvic examination should be primary features of this clinic. The sexually active teenagers and those who elect chastity

should be included in the Health Clinic for teenagers. Only those who understand and enjoy working with teenagers should man such clinics. Patient education and counseling should be indispensable units of such clinics!

At the same time, the school system needs to be enlisted and encouraged to teach Human Sexuality and Responsibility as a part of Family Life Education or Physical Education and Health Education. With the escalating cost to welfare of these pregnancies, perhaps the subject could even be introduced into math classes or civics classes! PTA, church groups and other community organizations need to be included in a community-wide program for teenage clinics and education.

REFERENCES

1. Hatcher, Robert et al.: "Contraceptive Technology," Personal Communication, 1977.
2. Huffman, John W.: "The Gynecology of Childhood and Adolescence," Philadelphia, W. B. Saunders, 1969, pg. 544; *Ibid,* pg. 545.
3. Sandberg, Eugene C.: "Psychological Aspects of Contraception; The Sexual Experience," Baltimore, Williams & Wilkins, Chap. 13.6, pg. 335; 1975.
4. Sarrel, P. M. and Davis, C. D.: "The Young Unwed Primipara," *Amer. J. Obstet. Gynec.* 95:722, 1966.
5. Semmens, J. and McGlamory, J.: "Teenage Pregnancies," *Amer. J. Obstet. Gynec.* 16:31, 1960.
6. Wallace, H. M.: "Teenage Pregnancy," *Amer. J. Obstet. Gynec.* 92:1125, 1965.



- *Scientific programs in 16 specialties: Allergy and Immunology; Chest Disease; Emergency Medicine; Gastroenterology; Internal Medicine; Neurology; Neurosurgery; Nuclear Medicine; Ophthalmology; Pathology; Pediatrics; Plastic Surgery; Public Health; Psychiatry; Radiology; Surgery*
- *Interdisciplinary program on Asthma*
- *Educational Exhibits*

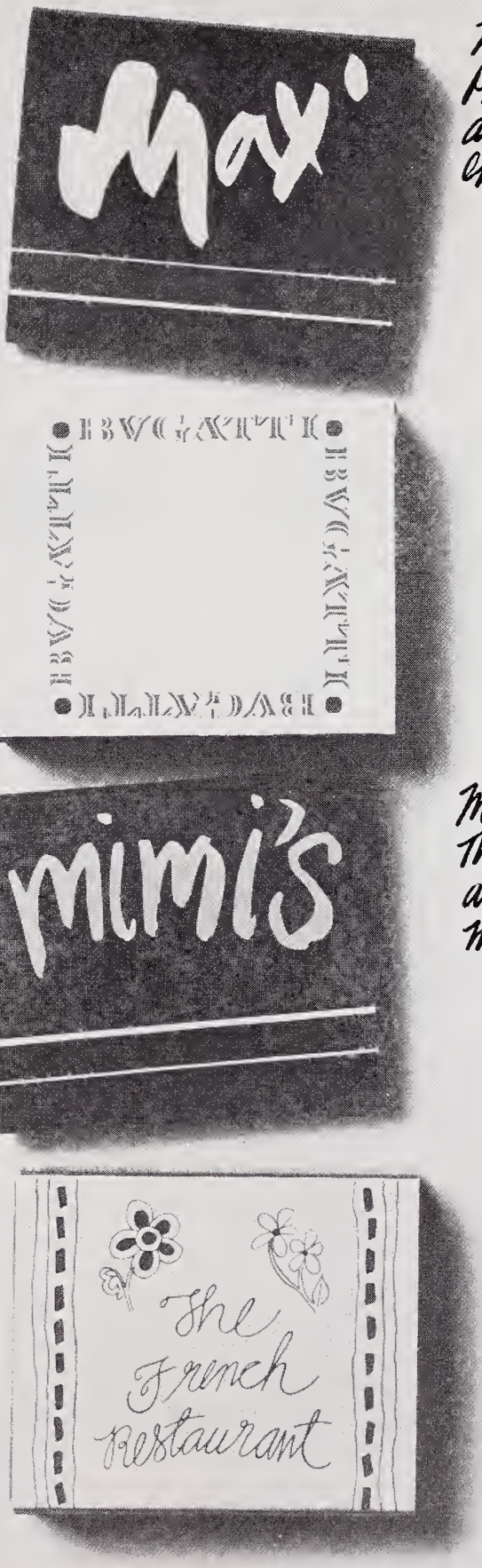
a pleasurable experience in continuing medical education

1977 MAG SCIENTIFIC ASSEMBLY

- *AMA Category 1 credit for all programs*
- *Luncheon and plenary session with a nationally-known guest speaker*
- *Alumni Night*

Omni International Hotel
downtown Atlanta
November 17-20, 1977

For details and registration information, write: 1977 Scientific Assembly, 938 Peachtree St., Atlanta, Ga. 30309, or call MAG, 404/876-7535 (toll free 1-800-282-0224 for long distance calls originating in Georgia).



Mix at Max'.
Prime beef, fresh seafood and late night live entertainment. 522-4442.

The most delightfully delicate dishes this side of the Appian Way. A fine Northern Italian restaurant and Club Bar. 659-0000.

Meet me at Mimi's.
The place to eat, drink and mix if the spirit moves you. 688-5900.

Superb, authentic Gallic cuisine in a garden-like setting. A Holiday Award-winning restaurant with a spirited French Bar. 659-0000.

Omni for all.

You'll find four of Atlanta's favorite restaurants all in one place.
Omni International, Techwood and Marietta Streets, downtown.

Serving the General Insurance needs of
the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

Capital Cadillac

SELLS AND LEASES
CADILLACS
FOR LESS THAN
ANY OTHER DEALER
IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

going into practice ? consider north carolina

North Carolina's Office of Rural Health Services Offers You:

—the chance to discuss practice opportunities in 60 communities from the coast to the mountains

—the opportunity to work with physician extenders if you so desire

—the chance to join a group, partnership, association or to establish a new practice

—the opportunity for you and your spouse to visit a community with the right kind of life-style and medical practice organization

—the opportunity to participate in the North Carolina Area Health Education Centers Program

The Office of Rural Health Services Has Information On 60 Communities For Your Consideration

Please Send Me More Information About North Carolina

Office of Rural Health Services
Department of Human Resources
Box 12200
Raleigh, N. C. 27605

Name _____ (First / Middle / Last)

Address _____ (Street)

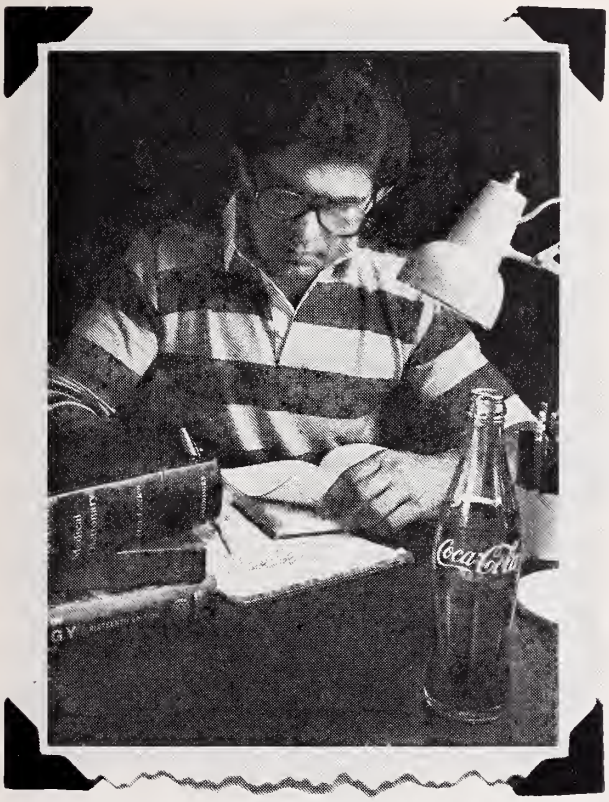
_____ (City / State / Zip Code)

Date Available _____

Home Phone _____ Work Phone _____

☐ Family Practice
☐ Internal Medicine
☐ OB/GYN
☐ Pediatrics
☐ Emergency Room
☐ _____

Coke adds life to... those special moments.



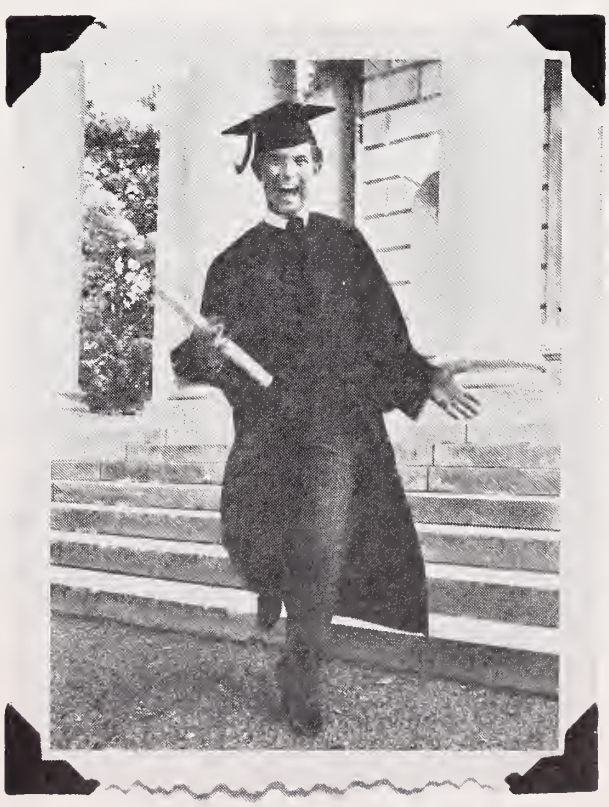
June 2: 2 A.M. Me! Cramming for Inorganic Chemistry finals. Man was I beat!



Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

"Coca-Cola" and "Coke" are registered trade-marks which identify the same product of The Coca-Cola Company.

A Method of Hernia Repair

SIDNEY APPEL, M.D., *Atlanta**

While this repair is more difficult than most, the decreased incidence of recurrence makes it worthy of consideration.

MANY TECHNIQUES have been described for inguinal hernia repair. Among these are the McVay, Bassini, and preperitoneal methods. In a paper by Lund, et al[1] there was an eight per cent recurrence after five years for all inguinal herniorrhaphies repaired by the McVay technique and a 13 per cent recurrence after five years by the Bassini repair. Although many authors present many different recurrence rates, these seem to be representative. Recurrence rates with preperitoneal repairs run as high as 32 per cent for direct repairs,[2] but only two per cent for indirect repairs with this method as with others. There has been a method performed first by Shouldice and later modified by Shearburn in which the recurrence rates for all herniorrhaphies were .2 per cent to 2 per cent by all reporting using this technique.[3, 4] For recurrent hernia repairs, the incidence is 2.7 per cent with the Shearburn modification of the Shouldice technique.[5]

This repair is more difficult than the more familiar types of herniorrhaphy, and expert knowledge of the inguinal anatomy is essential. A fine review of the anatomy of this region may be found in an article by Griffith.[6]

Technique: local anesthesia is preferred, although spinal or general anesthesia are acceptable. The standard oblique or transverse inguinal incision is employed and deepened down to the external oblique aponeurosis. The overlying subcutaneous tissue is dissected off the external oblique by sharp dissection laterally to free the external portion of the inguinal ligament. The external oblique aponeurosis is opened through the external ring and again with sharp dissection the internal portion of inguinal ligament is visualized. The ilioinguinal nerve is preserved. An incision is made in the cremaster muscle and external spermatic fascia overlying the cord structures and the former are removed from the cord, proximally at the internal ring, and distally as far as possible. Penrose drains are placed about the cord and elevated from the posterior inguinal wall which is the transversalis fascia.

If an indirect sac is present, it should be easily visualized. A direct weakness in the transversalis is also noted when present. For repair of an indirect hernia, the sac is dissected free from the cord structures and the transversalis fascia. The sac is usually opened and dissected down to non-attenuated peritoneum where the sac is transected and the perito-

* Suite 128B, 490 Peachtree St., NE, Atlanta, Ga. 30308.

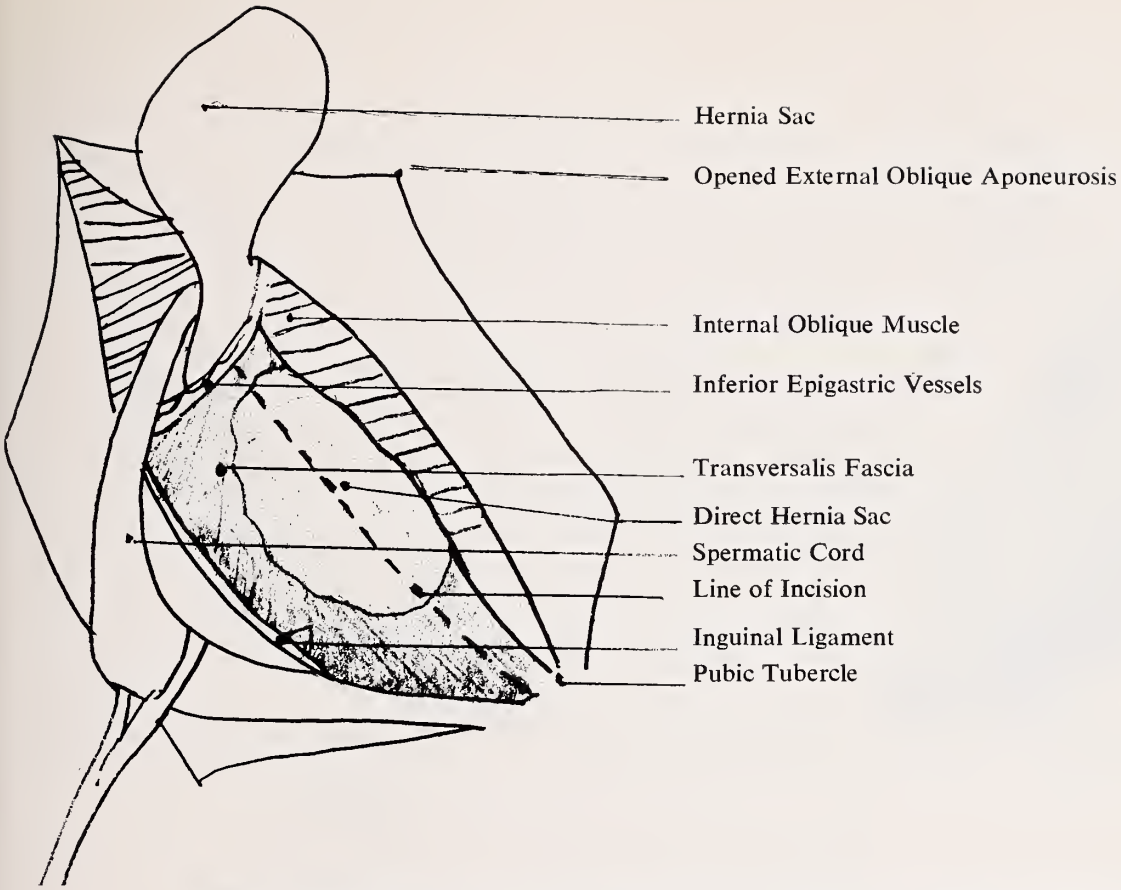


Fig. 1—Diagramatic view of inguinal floor showing direct and indirect hernial defects.

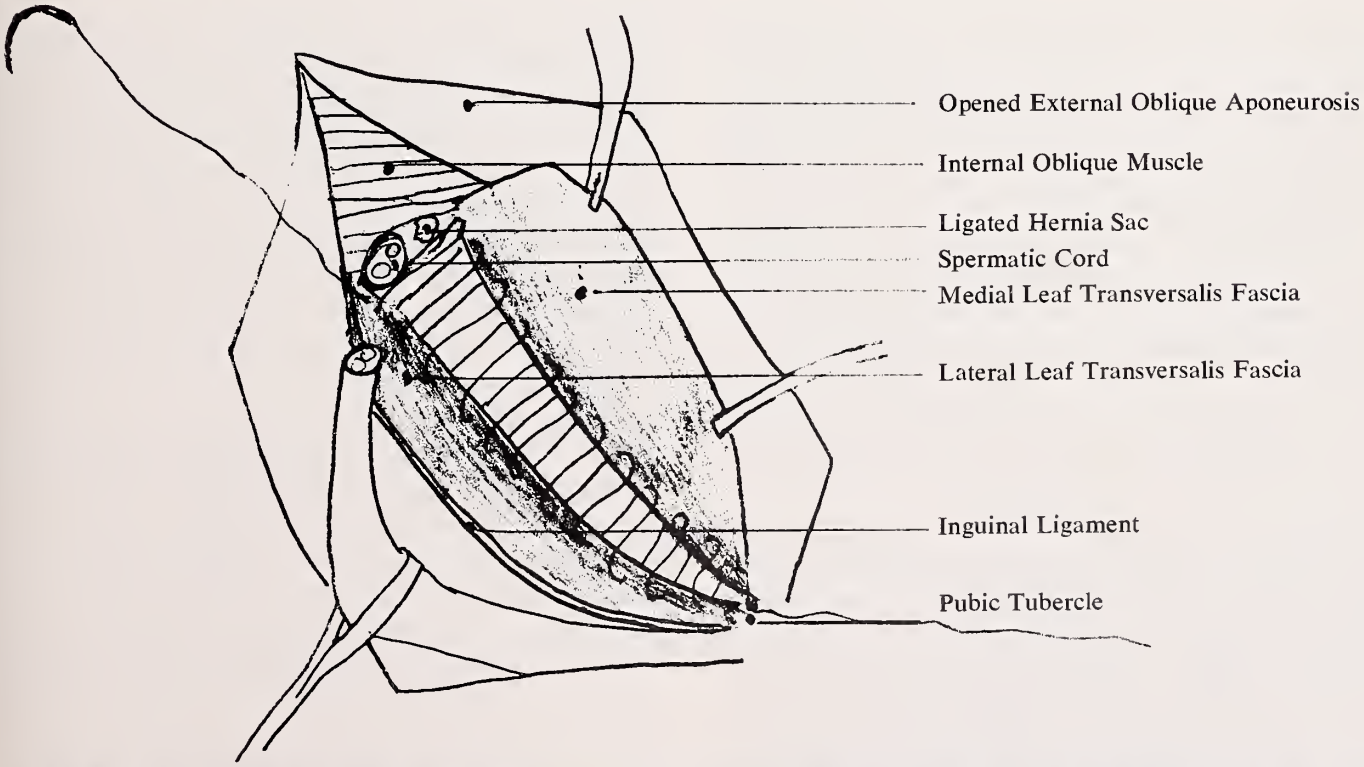


Fig. 2—The transversalis has been opened and trimmed if necessary, and the lateral leaf is being sutured to the underface of the medial leaf.

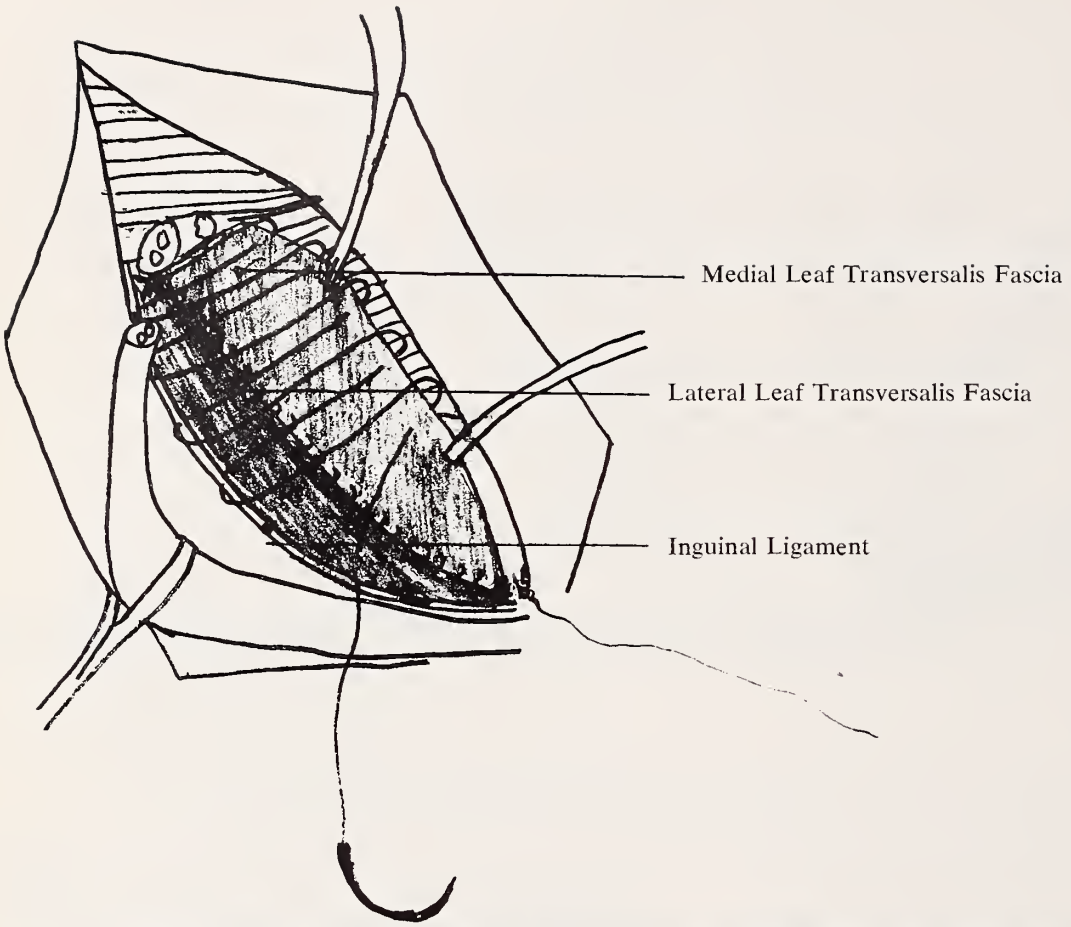


Fig. 3—The free edge of the medial leaf of the transversalis fascia is sutured to the inguinal ligament

neum then reapproximated with 0 or 2-0 chromic gut. Dissection of the sac especially at its base from the transversalis fascia is the most important factor and one may then invert it under the transversalis with or without resecting portion of the sac, with the same result in recurrence rate.

After dealing with the sac in an indirect hernia and before dissection of the sac in a direct hernia, the posterior wall of the inguinal canal is opened in the following fashion: the transversalis fascia at the inferior border of the internal ring is incised down to the pubic tubercle, taking care to avoid the inferior epigastric vessels (Fig. 1). Fine hemostats are placed on both leaves of the transversalis and again using sharp dissection the preperitoneal fat is dissected from the overlying transversalis fascia medially, until strong fascia is noted (even with a large direct hernia satisfactory fascia can almost always be found). Attentuated transversalis fascia is excised and the direct sac is not opened. At this time the femoral ring can be visualized and if a defect is found, the iliopubic tract may be reapproximated to Cooper's ligament with interrupted non-absorbable sutures. The posterior wall of the inguinal canal is then repaired by suturing the lateral leaf of the transversalis to the undersurface of the medial leaflet with non-absorbable suture (2-0 Prolene is easy to work with in this regard). The first suture is placed at the pubic tubercle and tied. A continuous suture line is made from this point laterally to reform a new internal ring (Fig. 2). The interval between bites is about 3 mm. The ring is made sufficiently tight so as to allow entrance of the tip of a forceps.

The suture is not tied at the internal ring, but is reversed in direction suturing the medial leaf of the transversalis fascia to the inguinal ligament again in continuous fashion until the origin of the suture is reached whereupon the ends are tied (Fig. 3). It is best not to pull the suture taut until the internal ring is reformed on the first layer, or when the pubic tubercle is reached on the second layer, to distribute the tension along the whole suture line proportionately. A second suture line is then made from the level of the internal ring to the pubic tubercle by suturing the edge of the internal oblique muscle and

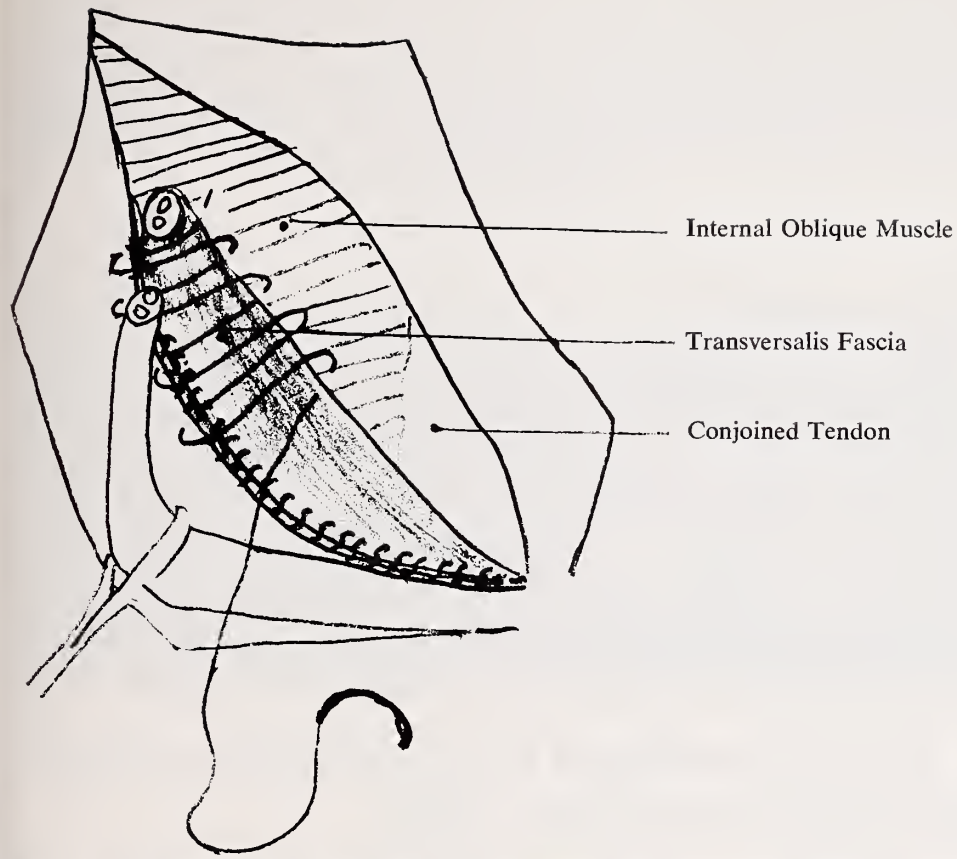


Fig. 4—The border of the internal oblique muscle and conjoined tendon if present, and sutured to the external oblique just above the inguinal ligament.

conjoined tendon, if it is present, to the inguinal ligament with a continuous non-absorbable suture (Fig. 4). This suture is then reversed, suturing the same structures, and is tied at the level of the internal ring. This layer tends to take the tension off of the transversalis fascial repair which is the primary repair of the inguinal hernia. The cord is then placed over these structures and the external oblique sutured over it with a continuous Prolene suture. The subcutaneous tissue is then reapproximated with interrupted sutures of fine plain gut. The skin is closed with sutures or steri-tape.

Aftercare: the patient is encouraged to ambulate as soon after surgery as possible. He is usually discharged on the first or second post-operative day, and is allowed back to work if the job is a sedentary one in a week to ten days or back to heavy manual labor at the end of approximately one month.

To summarize the important points of the technique:

1. Skeletonization of the cord.
2. Dissection of the cord structures from the internal ring.
3. High dissection of any sac with or without high ligation.
4. Examination of the posterior inguinal wall and then the femoral ring. Repair of a femoral defect if present.
5. Imbrication of the transversalis fascia to reform the internal ring.
6. A modified Bassini repair—that is: internal oblique muscle to inguinal ligament to take the tension off the transversalis fascia repair.
7. Use of non-absorbable suture material.

REFERENCES

1. Lund, Jorgen: "Inguinal and Femoral Hernioplasty," *Acta Chir. Scand.* 131:1-2, 72-80, 1966.
2. Dyson, William and Pierce, William: "Changing Concept of Inguinal Herniorrhaphy," *Arch. Surg.* 91:971-975, 1965.
3. Shearburn, Edwin and Myers, Richard: "Shouldice Repair for Inguinal Hernia," *Surg.* 66:2, 450-459, 1969.
4. Moran, Robert and Blick, Michael: "Collura, Mario," *Surg.* 63:3, 423-429, 1967.
5. Shearburn, Edwin: Personal Communication.
6. Griffith, Charles: "Inguinal Hernia: An Anatomic Surgical Correlation," *Surg. Clin. N. Am.* 39:531-556, 1959.



Lake Arrowhead. A guaranteed 8.6% annual return. And a great resort, too!

Take for example our million dollar Country Club that overlooks the sparkling 500 acre lake. Stretching out behind the Country Club is a magnificent hillside championship golf course, second to none in this entire area. We also have a beautiful Swin and Tennis Club with tournament courts and a huge pool, all waiting for your family.

Where does the guaranteed 8.6% annual return come in? It's made possible by our exciting and revolutionary marketing plan. If you purchase a Lake Arrowhead homesite under this plan, you will receive a guaranteed 8.6% annual return on the annuity premium upon maturity, which **will pay you back the original purchase price you paid for your beautiful Lake Arrowhead homesite and annuity.**

For complete information, call **266-1002** Visit our Atlanta office at 3400 Peachtree Road in the lobby of the Lenox Towers, or use this handy coupon. Remember, this is a limited offer.

Please send me free and complete information about Lake Arrowhead's new marketing concept under which I am guaranteed 8.6% annual return on the annuity.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

AMNG

LAKE ARROWHEAD

...where a sound opportunity awaits you.

Obtain the HUD property report from developer and read it before signing anything. HUD neither approves the merits of the offering nor the value, if any, of the property.
This ad does not constitute an offer to sell in any state where such an offer is prohibited.

The immunologic characteristics of the various serotypes will ultimately determine the management of this strain of infections.

Group B Streptococcal Infections in the Neonate

WILLIAM LEE TIFT, M.D., F.A.A.P., *Macon**

BETA HEMOLYTIC STREPTOCOCCI, which are now designated group B, were first described in 1887 as causing mastitis in cattle.[8] Following Dr. Lancefield's grouping of Beta strep in 1933,[14] group B streptococci were found to commonly inhabit human mucosal surfaces, especially the female genito-urinary tract. Serious adult infections (endocarditis, arthritis, and meningitis) were soon documented, but the first report of group B streptococcal meningitis in a neonate was made in 1958 by Nyhan and Fousek.[15] Since Dr. Hood in 1961[10] emphasized the association between group B streptococci in the vaginal flora and perinatal infection, this organism has rapidly gained in importance. Now in the 1970's, group B streptococci have become more common than *E. Coli* as a cause of overwhelming neonatal infections.[7]

Neonatal infections with group B streptococcus fall into two distinct categories. The early onset type is a fulminant septicemia which almost always begins in the first forty-eight hours of life and leads rapidly to death in more than half of the patients. In nearly all cases, the same serotype which is cultured from the infected newborn is present in the genito-urinary tract of the mother, suggesting a vertical intrapartum transmission. This mode of transmission is further supported by the high incidence (92%) of obstetric complications (premature or prolonged rupture of membranes, prematurity, and perinatal fever) seen in this early onset form of the disease.[3] The late onset type of group B streptococcal infection is a more localized infection, usually meningitis, with onset beyond the first ten days of life. This much less fulminant form of infection is nearly always caused by type III and is thought to be acquired post-natally either from nursery personnel or other outside sources.[2, 20] Babies with the late onset disease present with findings which are similar to other forms of infant meningitis—fever, irritability, lethargy, bulging fontanelles, and typical cerebrospinal fluid findings. The mortality rate of 15-20% in late onset group B streptococcal infections is also similar to other causes of neonatal meningitis.[3]

The clinical picture in early onset group B streptococcal infection is one of apnea in the first day of life proceeding rapidly to respiratory failure, acidosis, and shock.[17] Death occurs within twenty-four hours of onset and the mortality rate is somewhere between 50 and 75%. One shudders to think of how many of these infections have been missed in the past decade primarily because of the striking similarity between this disease and the respiratory distress syndrome.[1, 22] Even the chest X-ray is similar, since infants with group B septicemia form hyaline membranes exactly like those found in the respiratory distress syndrome. Once the distinction between group B septicemia and the respiratory distress syndrome was made, it became clear that these two entities are indeed separable—the early onset of apnea, rapid course, patchier infiltrates on chest X-ray, and shock along with a newly found high index of suspicion enable one to suspect group B streptococcal infection in its earliest stages. Prolonged rupture of membranes, which tends to prevent the respiratory distress syndrome, is associated with an increased incidence of group B streptococcal infection.[1] Other

2009 Vineville Ave., Macon, Ga. 31204.

less useful distinguishing features of group B infections include a low neutrophil count, organisms in the gastric aspirate, and lower inspiratory pressures required by the ventilator.[1, 22]

A look at the incidence of group B streptococcal infections will serve to underscore the need to conquer the immense management problems posed by these infections. Severe neonatal infections with these organisms occur in three of every one thousand live births with a resulting mortality of about one per thousand. Even this high mortality rate is an underestimate since about half of the survivors are left with neurologic sequelae.[11] The incidence of the maternal carrier state—that is, positive vaginal, cervical, or anal cultures at the time of delivery—varies from 5-25%.[24] Of the husbands of positive mothers, 40-50% have positive urethral cultures.[8] This picture of neonatal group B streptococcal infection as venereal disease affecting the offspring may be one of the keys to the successful management of this increasingly common problem. Both the pathogenicity of group B streptococci and their presence in the female genito-urinary tract have been recognized for many years, but only recently have these organisms posed a major threat to the neonate.[24]

The first and most obvious approach to the management of group B streptococcal infections has been the pediatrician's approach: treatment of the infected neonate. The early onset form of this infection is extremely difficult to cope with because of the paucity of early signs and symptoms to suggest its presence. Even with early recognition and institution of "appropriate" therapy, more than half of these infants rapidly develop respiratory distress, shock and death. Unlike the familiar group A Beta hemolytic streptococcus whose exquisite sensitivity to the penicillins has remained constant, group B streptococcus is relatively resistant to penicillin requiring much higher mean bacteriocidal concentrations of the drug.[19] Kinetic studies of *in vitro* killing show the combination of ampicillin and gentamycin to be superior to ampicillin alone,[19] and this combination is now recommended as the antibiotic treatment of choice along with supportive measures such as glucose, calcium, whole blood, and assisted ventilation. However, a series of articles in the August 1976 issue of *The Journal of Pediatrics* has produced some disturbing facts. The first four articles are case reports of neonatal infections with group B streptococcus type III which recurred several weeks after presumably adequate therapy of either the early or late onset type of sepsis/meningitis.[5, 6, 21, 23] The fifth article proves that a two-week course of parenteral penicillin therapy, with or without gentamycin, fails to eradicate the type III group B streptococcus from infected newborns.[16] Eighty per cent of patients so treated had throat cultures positive two weeks following therapy. Early diagnosis and treatment of neonatal group B streptococcal infections is essential and requires a high index of suspicion by obstetricians and pediatricians alike, but this is clearly not enough. In order to fight life-threatening infection which is both difficult to diagnose and impossible to treat, one must look to prevention.

The second approach to management, that of the obstetrician, involves the next logical step in the pathogenesis of group B streptococcal infections: the antibiotic treatment of pregnant women colonized with group B streptococci. Hall, et al. (1976), reported a prospective study conducted among third trimester women with cervical or urethral colonization with group B streptococci.[9] The colonization rate was found to be 7%, and these culture-positive carriers were arbitrarily divided into two groups. The treatment group received ampicillin 500 mg. four times daily for seven days while the control group received no treatment. A significant reduction in the carrier rate was noted three weeks after therapy in the treated group, but this difference was undetectable at the time of delivery. Other antibiotic regimens (such as those which include husbands) may prove more effective but other problems exist. This same study confirms an earlier finding of significant numbers of mothers who carried the same group B streptococcal serotype as their infected offspring but who were culture negative prior to delivery.[8, 9] This points up the difficulty of recovery of group B streptococci which has plagued all of the epidemiologic studies to date. For example, as many as one third of serious group B streptococcal infections in neonates may be caused by nonhemolytic strains.[18] Such organisms are readily cultured from the blood of infected infants, but can easily be missed on maternal screening cultures, many of which depend upon hemolysis as the first step in detection. Again, one must strive to improve both laboratory facilities and prophylactic regimens aimed at group B streptococcal carriers, but neither of these areas promises to hold the key to the eradication of this disease.

The ultimate answer to the management of group B streptococcal infections undoubtedly lies in the immunologic characteristics of the various serotypes. The early onset form of the disease may be caused by any of the five serotypes (Ia, Ib, Ic, II, and III), but Ia appears to be the most virulent.[11] The late onset infections are almost all caused by type III, as are those early onset infections which involve meningitis; indicating that type III organisms have the highest propensity for meningeal invasion.[2] Klesius, et al., in 1973, demonstrated that *in vivo* killing of group B streptococci depends upon both a plasma opsonizing factor which enhances phagocytic activity and type-specific agglutinins.[13] In the only known

survivor of type Ia early onset infection, both mother and baby were shown to have phagocytic activity against Ia and the plasma opsonizing factor which enhances phagocytosis.[12] This case takes on even more significance when one realized that whereas 95% of all adults possess opsonins for Ib, Ic, II, and III, only 5% of those tested had opsonins for type Ia.[12] More recently, maternal antibody deficiency has been correlated with an increased susceptibility to neonatal group B streptococcal infection.[4] Serums from seven women who gave birth to infants with invasive type III infections were all deficient in antibody. In contrast, of twenty-nine pregnant type III vaginal carriers whose infants were healthy, twenty-two had serums containing antibody to type III antigen. In this same study, it was shown that when antibody is present in mother's serum, it is also present in cord blood, indicating that passive transfer of antibody across the placenta does occur.[4] These observations—survival in the presence of type Ia and type III antibody, infection in the absence of type III antibody, and placental passage of antibody—hold the promise of prevention of group B streptococcal infection by immunization. Until this promise becomes a reality, obstetricians and pediatricians must cooperate with bacteriologists, neonatologists and immunologists to achieve the best possible outcome with available methods.

REFERENCES

1. Ablow, R. C., Driscoll, S. G. et al.: "A Comparison of Early-Onset Group B Streptococcal Neonatal Infection and the Respiratory Distress Syndrome of the Newborn," *NEJM* 294:65, 1976.
2. Baker, C. J. and Barrett, F. F.: "Group B Streptococcal Infections in Infants," *JAMA* 230:1158, 1974.
3. Baker, C. J., Barrett, F. F., Gordon, R. C. and Yow, M. D.: "Suppurative Meningitis Due to Streptococci of Lancefield Group B: A Study of 33 Infants," *J. Pediatrics* 82:724, 1973.
4. Baker, C. J. and Kasper, D. L.: "Correlation of Maternal Antibody Deficiency With Susceptibility to Neonatal Group B Streptococcal Infection," *NEJM* 294:753, 1976.
5. Broughton, D. D., Mitchell, W. G., Grossman, M., Hadley, W. K. and Cohen, M. S.: "Recurrence of Group B Streptococcal Infection," *J. Pediatrics* 89:183, 1976.
6. Dorand, R. D. and Adams, G.: "Relapse During Penicillin Treatment of Group B Streptococcal Meningitis," *J. Pediatrics* 89:188, 1976.
7. Feigin, R. D.: "The Perinatal Group B Streptococcal Problem: More Questions Than Answers," *NEJM* 294:106, 1976.
8. Franciosi, R. A., Knostman, J. D. and Zimmerman, R. A.: "Group B Streptococcal Neonatal and Infant Infections," *J. Pediatrics* 82:707, 1973.
9. Hall, R. T., Barnes, W. et al.: "Antibiotic Treatment of Parturient Women Colonized With Group B Streptococci," *Am. J. Obstet. Gynecol.* 124:630, 1976.
10. Hood, M., Janney, A. and Dameron, G.: "Beta Hemolytic Streptococcus Group B Associated With Problems of the Perinatal Period," *Am. J. Obstet. Gynecol.* 82: 809, 1961.
11. Horn, K. A., Zimmerman, R. A., Knostman, J. D. and Meyer, W. T.: "Neurological Sequelae of Group B Streptococcal Neonatal Infection," *Pediatrics* 53:501, 1974.
12. Horn, K. A., Meyer, W. T., Wyrick, B. C. and Zimmerman, R. A.: "Group B Streptococcal Neonatal Infection," *JAMA* 230:1165, 1974.
13. Klesius, P. H., Zimmerman, R. A. et al.: "Cellular and Humoral Immune Response to Group B Streptococci," *J. Pediatrics* 83:926, 1973.
14. Lancefield, R. C.: "Serological Differentiation of Human and Other Groups of Hemolytic Streptococci," *J. Exp. Med.* 57:571, 1933.
15. Nyhan, W. L. and Fousek, M. D.: "Septicemia of the Newborn," *Pediatrics* 22:268, 1958.
16. Paredes, A., Wong, P. and Yow, M.: "Failure of Penicillin to Eradicate the Carrier State of Group B Streptococcus in Infants," *J. Pediatrics* 89:191, 1976.
17. Quirante, J., Ceballos, R. and Cassady, C.: "Group B Beta Hemolytic Streptococcic Infection in the Newborn: I. Early Onset Infection," *Am. J. Dis. Child.* 128:659, 1974.
18. Roe, M., Todd, J. K. and Favara, B. E.: "Nonhemolytic Group B Streptococcal Infections," *J. Pediatrics* 89: 75, 1976.
19. Schauf, V., Deveikis, A., Riff, L. and Serota, A.: "Antibiotic-Killing Kinetics of Group B Streptococci," *J. Pediatrics* 89:194, 1976.
20. Steere, A. C., Aber, R. C. et al.: "Possible Nosocomial Transmission of Group B Streptococci in a Newborn Nursery," *J. Pediatrics* 87:784, 1975.
21. Truog, W. E., Davis, R. F. and Ray, C. G.: "Recurrence of Group B Streptococcal Infection," *J. Pediatrics* 89:185, 1976.
22. Vollman, J. H., Smith, W. L., Ballard, E. T. and Light, I. J.: "Early Onset Group B Streptococcal Disease: Clinical, Roetgenographic, and Pathologic Features," *J. Pediatrics* 89:199, 1976.
23. Walker, S. H., Santos, A. Q. and Quintero, B. A.: "Recurrence of Group B III Streptococcal Meningitis," *J. Pdiatrics* 89:187, 1976.
24. Yow, M.: "Group B Streptococci: A Serious Threat to the Neonate," *JAMA* 230:1177, 1974.

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

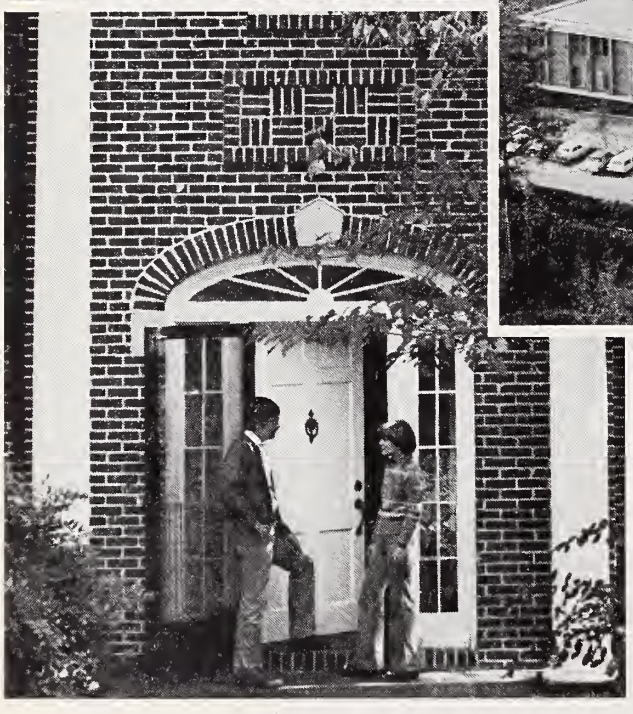
☐ Breast Prosthesis—Foundation Garments

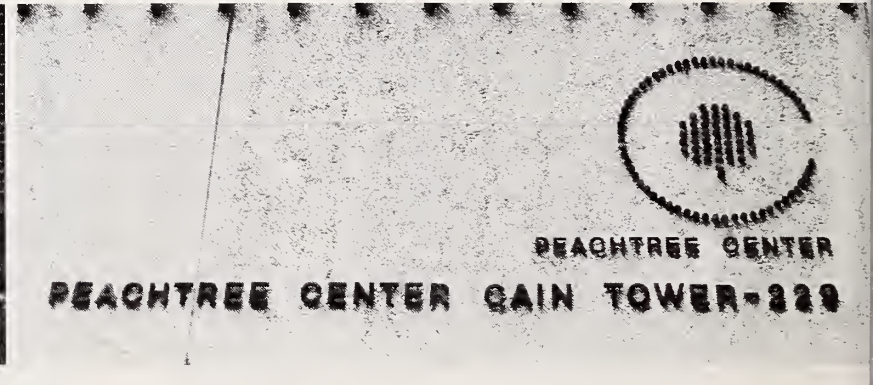
82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972











PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Important.....

It may be a totally new experience for you or it may be the continuation of a secondary career.....

As a doctor in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found. . . . service to the community, state and nation.

In addition, many persons have found that the change of <u>place</u> and change of <u>pace</u> has resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for Georgia Army National Guard units. These "drill" periods, as we call them, can be very flexible to suit the needs and training requirements of the unit. Physicians even receive monetary support for attending CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS. If you need that CHANGE OF PLACE and CHANGE OF PACE, contact



Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662



don't look in the yellow pages...

Many of the goods and services you need are advertised in your Journal. *Below is a classified listing of companies who have advertised a minimum of three times in the past six months or who will be advertising a minimum of three times in the next six months. These advertisers make the* Journal *possible. Please help us show them our appreciation by taking a few minutes to let them know you are checking them first.*

ASSOCIATIONS
Georgia Society of CPAs
Pharmaceutical Manufacturers Association
Weight Watchers of Greater Atlanta

AUTOMOBILE DEALERS
Capital Automobile—*Cadillac*
Chris Motors—BMW
FAF Motorcars, Inc.—*Ferrari*
Hickman Datsun

BOOK PUBLISHERS
The Harrison Company

COLLECTION AGENCIES
Creditor's Mercantile

CME BOOKKEEPING
Physician's Registry

DATA PROCESSING SERVICES
Data Med Health Systems

EDUCATIONAL SERVICES
Georgia Cancer Line

HEARING AIDS
Beltone Electronics

HOLTER MONITORING
Non-Invasive Cardiac Services,

HOTELS
Omni International, *Atlanta*
Terrace Garden Inn, *Atlanta*

INSURANCE
Blue Cross and Blue Shield of Georgia/Atlanta
Dickey-Mangham Company
John Lusk
Potter-Holden & Company

INTERIOR DESIGN
River Interiors

INVESTMENT COUNSELORS
Consolidated Planning Corporation
Preferred Partnerships, Inc.

MANAGEMENT CONSULTANTS
Practice Productivity, Inc.

MILITARY
Georgia Army National Guard
U.S. Air Force
U.S. Navy

OPTICIANS
Walter Ballard

PERSONNEL AGENCIES
O'Keefe Personnel

PHARMACEUTICAL COMPANIES
Armour Pharmaceuticals
Burroughs Welcome Co.
Dorsey Laboratories
Eli Lilly and Company
Merck Sharp & Dohme
Ortega Pharmaceuticals
Pennwalt
A. H. Robins Company
Roche Laboratories
Roerig
Smith Kline & French
Squibb & Sons, Inc.
The Upjohn Company
Warner Chilcott

PRACTICE BROKERS
Sherwood Commercial Brokers

PRACTICE OPPORTUNITIES
North Carolina Dept. of Human Resources
Qualicare, Inc.

PSYCHIATRIC HOSPITALS
Brawner Hospital, Inc.
Hill Crest
Metropolitan Psychiatric Center
Peachford Hospital
Peachtree and Parkwood Hospitals
Valley Psychiatric Hospital
Willingway Hospital

REAL ESTATE
Duluth Professional Building
Lake Arrowhead
Scott Hudgens Properties

RESTAURANTS
Bugatti
The French Restaurant
Max'
Mimi's

SCHOOLS
Woodward Academy

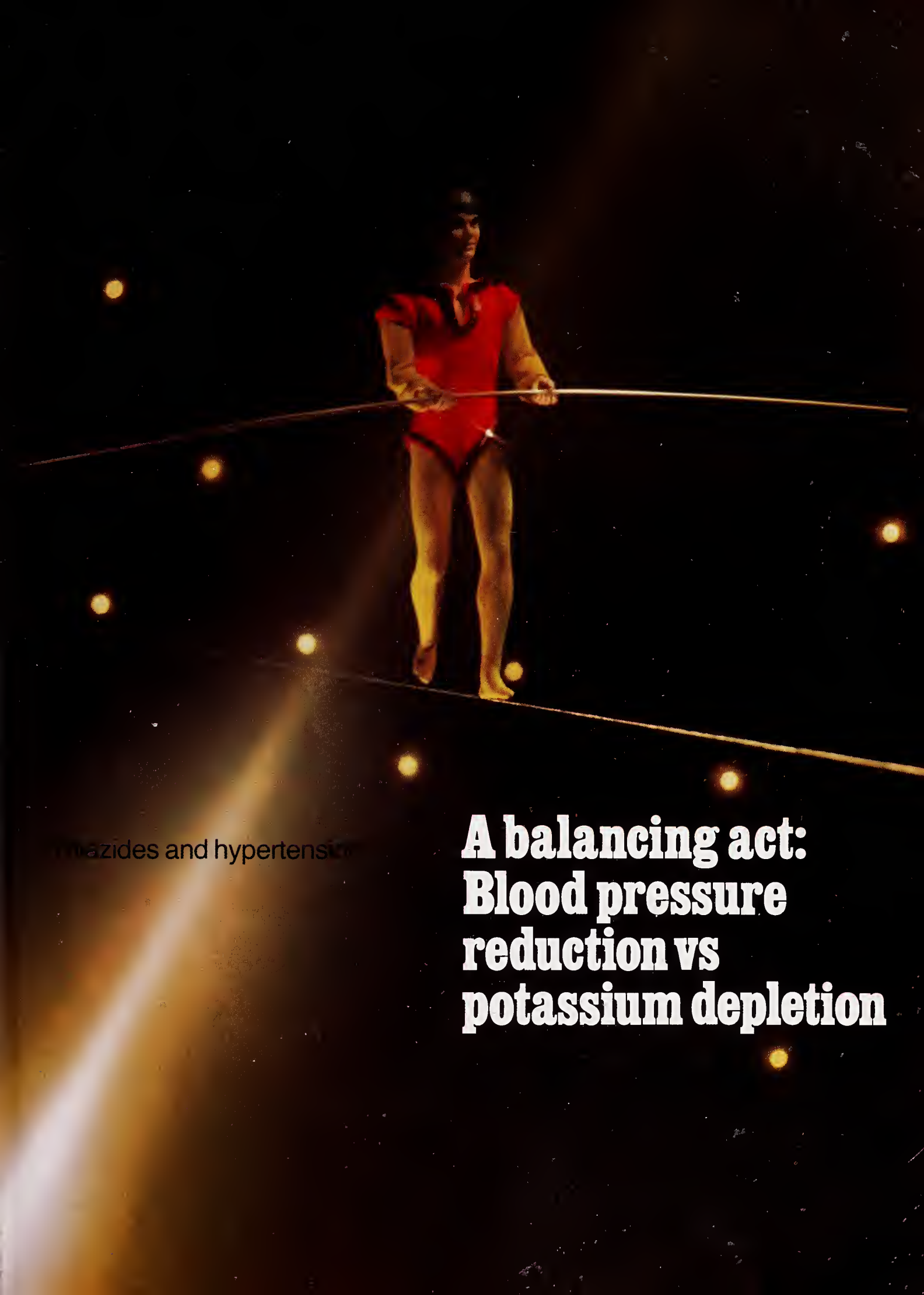
SILVER INVESTMENTS
William Waronker

SOFT DRINK MANUFACTURERS
Coca-Cola Company

SURGICAL SUPPLIES
Eager and Simpson
Estes Surgical Supplies

SWIMMING POOLS
Aqua-Rama

check your JOURNAL first.



azides and hypertensi

A balancing act: Blood pressure reduction vs potassium depletion

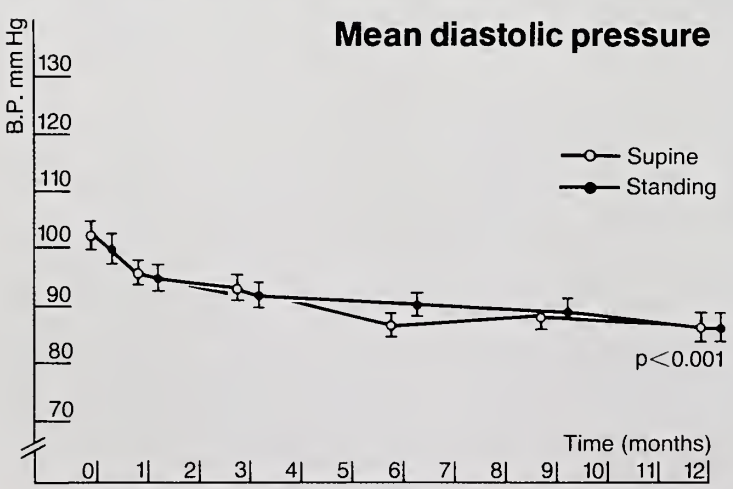
From a 1-year study of 18 patients with mild uncomplicated hypertension published in The Lancet*

Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

Diastolic blood pressure down 12-15%



"The mean pretreatment blood pressure was 170/103 mm Hg (supine) and 166/100 mm Hg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88 mm Hg (supine) and 142/88 mm Hg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762, 1975.



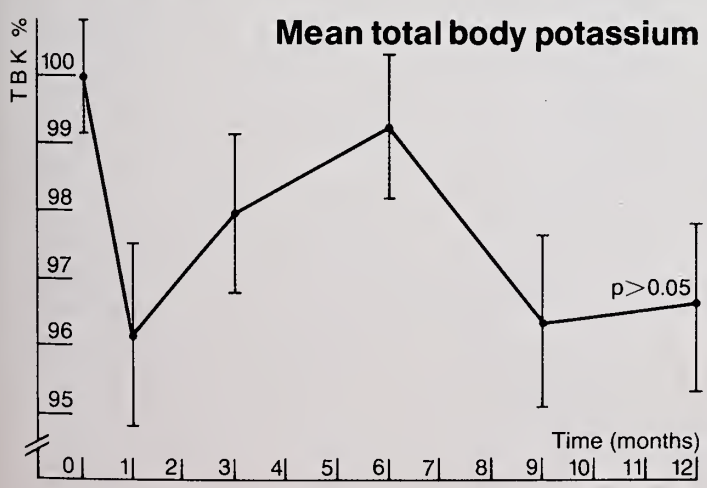
Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day
Naturetin®
Bendroflumethiazide Tablets N.F.

NATURETIN®-2.5
NATURETIN®-5
NATURETIN®-10
Bendroflumethiazide Tablets N.F.

DESCRIPTION

Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS

The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS

Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS

Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS

Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS

Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis. *Central Nervous System:* dizziness, vertigo, paresthesia, headache, and xanthopsia. *Hematologic:* leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia. *Dermatologic-Hypersensitivity:* purpura, photosensitivity, rash, urticaria, and necrotizing angiitis (vasculitis, cutaneous vasculitis). *Cardiovascular:* orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. *Other:* hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION

Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE

Store at room temperature; avoid excessive heat.

HOW SUPPLIED

2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

SQUIBB®

©1977 E.R. Squibb & Sons, Inc. 477-501

"Rising costs are being exploited as an excuse for an all out move against the private practice of medicine and health care."

National Health Insurance

JAMES H. SULLIVAN, M.D., *Columbus

I WOULD LIKE TO PRESENT a few facts, a few questions, and a few answers regarding the possibility of National Health Insurance for America. The facts are correct. We must disseminate this information to educate our citizens and forewarn them of this bureaucratic nightmare.

The tragic flaw in any federal, social, or health program is the bureaucracy formed which controls it. This usually comprises 20-50 percent of the total expenditure of these funds.

Social welfare spending hit an all time high in 1976. The Department of HEW says that during 1976 social welfare programs cost the nation's taxpayers 331 billion dollars (45 billion more than it cost the same taxpayers in fiscal 1975). Social welfare programs in 1976 cost each American citizen, man, women and child, $1,760.19. In 1960 only 26 percent of the federal budget was spent on social welfare programs, but in 1976, 56 percent of the federal budget was spent on social welfare programs.

A very interesting statistic is that 6.6 percent of the income of the nation's families went toward total health care cost in the United States which totaled 140 billion dollars in 1976. This includes insurance, medicine, medical bills, hospital bills, glasses, dentures, etc. The taxes paid to the United States, State and local governments took 34 percent of the income of families of this United States.

Why do we have rising health care cost? No longer can Washington accuse us doctors of being some 50,000 short in numbers. Washington cannot refute the peerless excellence of American medicine as compared to worldwide medicine. Washington cannot deny what the polls show, and that is that most Americans are satisfied with the quality and of the availability of their care. Rising costs are being exploited as an excuse for an all out move against the private practice of medicine and health care. We doctors are concerned about the cost issue, but contrary to the thinking of most politicians, we are not the culprit. The climb in cost is largely due to impersonal factors that far exceed the personal ability of any health care provider to control them. They are: 1. growth and expansion of clinical competence and technology; 2. growth of health insurance and its incentives to better care; 3. the relentless surge in professional liability premiums; 4. greater longevity and thus a greater incidence of chronic illness (in other words, you cure one disease, the patient lives longer and is certain to get a second disease process); 5. steady inflation, and 6. most important, the network of administration and procedural expenses engendered by federal involvement in health care.

Did you know that hospitals employ five times as many people as the automobile industry? (Two million people work in hospitals.) Did you know what the impact of an increase in the minimum wage on hospital cost is? Raising the minimum wage in areas such as housekeeping, laundry, and kitchen also causes a ripple "effect" which raises salaries of other personnel to maintain a rational wage structure. A 30¢-per-hour increase in 1974 of the minimum wage initially had an impact of 29 million dollars on hospital wages, but the ripple effect had an impact of 450 million dollars. Did you know that each hospital patient in the United States in 1976 paid an average of $6.00 per day to cover malpractice insurance

* Treasurer of the Medical Association of Georgia. Dr. Sullivan's address is 1430 3rd Ave., Columbus, Ga. 31901. Reprinted with permission from the *Bulletin of the Muscogee County Medical Society.*

costs for the hospital? Did you know that one in three hospital employees have special training as opposed to one in seven people in industry?

When socialized medicine and national health insurance fails, as has happened in England and other countries, the blame will not fall on the government; it will fall on the physicians, hospitals, nursing homes, and pharmacists. National health insurance will bankrupt this nation just as surely as it has England. The private practice of medicine, like the private enterprise American system, is based on the principle that a person is entitled to what he earns and pays for.

"In seven years, the number of administrative employees of the British health service increased almost twice—from 780,000 to 1.3 million *non-medical* employees. . . . National health insurance will bankrupt this nation just as surely as it has England."

The record of HMO or Health Maintenance Organizations in the United States is simply awful. Coop health groups traditionally have administrative costs amounting from 50-97 percent of the total money available. National Health Insurance and HMO group medicine invites assembly line medicine. Liberal congressmen and politicians have ignored the overall rise in cost of living and basic cost of inflation which in essence is uncontrolled deficit spending by government itself.

The annual budget of HEW (which is a bureau determined to cut costs and transform American medical health care) is greater than the total cost of all health care in this nation today. If honest cost savings were the real issue, the greatest boon to the American citizen today would be the abolition not of the practice of private medicine, but rather the Department of HEW.

Let's think of catastrophic illness and insurance. Catastrophic illness insurance is thought necessary by many but when the facts are known it is a typical bureaucratic sham. A $10,000 bill for the patient in the hospital is extremely rare. Three out of 1,000 patients have expenses over $1,000 and 80 percent of these are either Medicare or psychiatric patients. A family of four in the 25-35 age bracket would pay $52.00 a year to a private insurance company for a $10,000 deductible catastrophic insurance policy. Studies by private insurance companies as well as by a government-appointed study committee, reveal that catastrophic national health insurance the first year would cost $370.00 for the same family of four in this 25-35 age group. Where is the extra $318.00 per year to go? To bureaucratic boondoggling.

If smarter brains could prevail, the cost of a citizen's health insurance could be a direct tax credit against the federal income tax so that a taxpayer could deduct the entire cost from his tax bill. This would certainly be superior to the half-hearted deduction that now exists.

Any open-ended program such as national health insurance will encourage unnecessary utilization of benefits. If our medical system is indeed approaching a crisis due to rising costs, it is not because of the lack of government planning or intervention but rather because of the sheer weight of all government programs, regulations and paperwork they entail. A government that cannot even run a medical program for the poor and aged, or deliver the mail on time at a reasonable cost, can hardly call itself qualified to administer a national health insurance program.

Of all the proposals for national health insurance, the overwhelming idea is to try to provide cost containment, but never once is mentioned the quality of medical care.

Our medical records can always be surveyed by the prying eyes of bureaucrats. The national health insurance PSRO standards will expose even your most private records to anyone in government. On a computer with your one big number will be your health record, any legal problems, income tax returns, bank accounts, parking tickets, court decisions, credit cards, financial statements, misdemeanors, licenses, and down the line.

The arrival of Mr. Carter at the White House with his ideas of national health insurance makes it more necessary than ever for Americans to see what can be learned from Britain's example for national health insurance. In seven years, the number of administrative employees of the British health service increased almost twice, from 780,000 to 1.3 million non-medical administrative employees. British doctors say bluntly that their British National Health Service is on the brink of collapse. The British patient can see nothing very wrong, even though he has to wait a long time at a clinic and up to a year or more for non-urgent hernia operations. The reason for this is that the British people have never known anything else. They are accustomed to second class

"Co-op health groups have administrative costs amounting from 50-97% of the total money available. . . . The annual budget of HEW is greater than the total cost of all health care in this nation today."

standards of medical service because it took 30 years for the superb medical care of Britain to demise. The truck with defective brakes and steering is no less headed for disaster in the early stages of its run down hill than when it crashes through the brick wall at the bottom. But the truck was actually doomed from the start unless someone had managed to deflect it.

Even though Carter advocates national health insurance, Senator Kennedy is intent upon the passage of a bill that bears his name. Senator Kennedy has said that if anything else is passed for national health insurance other than his own health security plan, this country will wither and die. Senator Kennedy will not let a Georgia peanut broker take over his medical field.

The financing for national health insurance will amount to a political and financial nightmare. It is anticipated by the same actuary firm which studied catastrophic insurance programs that over 130 billion dollars in start-up funds would be needed for the first year of a comprehensive national health insurance.

HEW recently released the list of physicians who in 1975 received large sums of money. Of the first 112 doctors checked, only 32 were correct as listed. One physician had retired 12 years previously and was listed as receiving $233,000. Another physician who had died in 1974, one year before the time period, was listed as receiving $250,000. The list of physicians released by HEW has got to be one of the sloppiest performances in the history of American bureaucracy. If the AMA were to put out data this inaccurate, the press would have us for breakfast and properly so. For this reason HEW ought to be held similarly accountable.

What can we do? 1. Education. We can inform the public by spreading the flaws of the cost and the bureaucratic nightmare of national health proposals. 2. We can encourage Congress to repeal the PSRO and HSA laws and other social legislation programs and try to keep a right to privacy in our record-keeping system. 3. We can court the press.

It is so easy to be against something, but it is very difficult to stand up for something such as private enterprise, the private practice of medicine, the right to work, the right for freedom, and the right to be an American citizen.

MAGNET '77 TENTATIVE PROGRAM
"CONTROLLING COSTS IN THE MEDICAL PRACTICE"

Saturday 9:00 a.m.-6:00 p.m.

The importance of cost control
Selection and proper use of equipment
Financial systems
The cost of personnel
Collections/Insurance

Sunday 9:00 a.m.-12:00 Noon

What happens when you open your mouth—Do you realize the importance of your spoken image?

Final program and additional details will be sent in Mid-September.

MAGNET '77 REGISTRATION FORM

Name . . . . . **Address** . . . . .

County Medical Society . . . . . **MAG members?** . . . . .

Hotel Request: Yes . . No . . Single . . . . Double . . . . Arrive . . . . Depart . . . .
($28.00) ($34.00)

Late Arrival? . . . . . **(confirmation will be sent from hotel)**

I will . . will not . . attend cocktail reception. My spouse will . . will not . . attend.

Registration Fees (includes conference, all materials, speakers and reception):

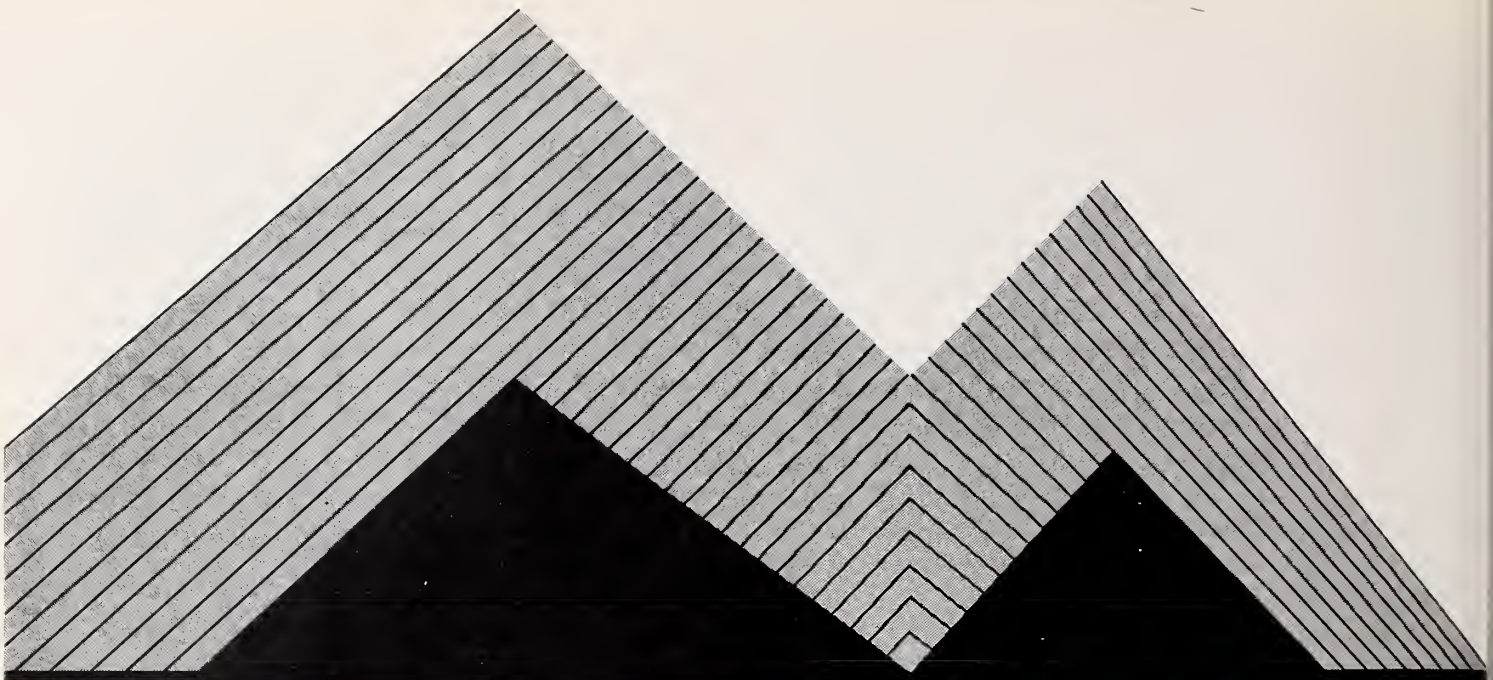
MAG Members & staff $35.00 **Non Members & staff $50.00**

Guests: . . . . . **Fees enclosed $** . . . . . .

. . . . . .

. . . . . .

Return to: MAGNET '77, 938 Peachtree St., Atlanta, Ga. 30309



MAGNET '77

IS THIS THE ANSWER?

OCTOBER 22-23

TERRACE GARDEN INN
ATLANTA



TERRACE GARDEN INN...

You'll Open Your Mouth Wide and say, "Ah-h-h, It's Beautiful!"

- Enjoy our luxurious rooms and suites.
- We're in a Prime Location—across from 200 stores including Neiman-Marcus, Saks Fifth Avenue, Lord & Taylor, Tiffany, Rich's.
- We're in Atlanta's prettiest residential and business area...and right off I-75-85.
- Dine in our dramatic, multi-level GARDENTREE RESTAURANT.
- For a fast bite, there's our bright, cheerful SUN FLOWER Coffee Shop.
- Play tennis on our professional courts with complete locker facilities. Rental equipment, too.
- Swim in our beautiful, cascading tiered pool.
- Have FUN in our Corner Hearth Lounge with live entertainment nightly (except Sunday).

Call Collect 404/261-9250 for reservations

Terrace Garden Inn
3405 Lenox Road Atlanta, Ga. 30326



By the time she can have a baby of her own, will she be able to afford to?

Hospital and doctor costs for having a baby have risen from a national average of $425 in 1967 to nearly $1,150 today.

Unless something is done about it, people may see a $3,400 bill when they have a baby in 1997.

You couldn't afford that. Neither could we.

That's why Blue Cross and Blue Shield Plans, working with doctors and hospitals across the country, have introduced a number of programs designed to help slow down dramatically rising health care costs.

What we are doing to hold down rising health care costs.

Many Blue Cross and Blue Shield Plans have programs that allow qualified patients to be discharged from the hospital sooner. The hospital provides whatever medical services they need *at home*. At a cost far lower than that of an extra day — or days — in the hospital.

Under another new program, some surgical patients scheduled for a hospital stay can have their lab and X-ray tests done as outpatients. Instead of spending a $130 day in the hospital waiting for test results, the patient can return home or even go back to work until the results are in.

A third cost-cutting program in many areas is encouraging certain kinds of surgery to be performed on an "in by nine, out by five" basis. By getting the patient back home the same day, it's easier on him. And on his pocketbook, too.

We're also working with doctors' review committees to make sure that the medical procedure and tests provided are really needed. It's a cooperative effort that's saving us all millions of dollars each year. And we're also working with various planning agencies to help make sure only needed services are available.

All of these are steps that can help hold down rising health care costs. Whether or not they will depends on the cooperation of each and every one of us.

What you can do to help.

The closer you watch every health care dollar, the less increase you may have in the rates you pay for health coverage. Ask for — and *use* — the kind of cost-cutting programs we've described here.

Because only if doctors and hospitals realize that *you* are as vitally concerned as we are — and they are — will these programs be offered and used on a widespread basis.

You can also join the more than 90 million people who subscribe to not-for-profit Blue Cross and Blue Shield Plans. We annually return over ninety cents of every dollar paid in for the health care of our members, and never cancel a single person because of a poor health record.

If you'd like to know more about what we're doing to hold down costs, and what you can do to help, write Box 4445, Atlanta, GA 30302 for our free booklet, "How All of Us Can Help Each of Us Hold Down Health Care Costs."

Blue Cross
Blue Shield
of Georgia
Atlanta/Columbus

All of us helping each of us.

MAGNET 77—Is This the Answer?

MONEY—HOW TO MAKE it, how to spend it and how to keep some for yourself. That is the theme and thrust for the 1977 MAGNET Conference.

The cost of medical care in America has changed from a social issue for discussion to an economic problem of major importance, not only for the public, but for providers. Actual practice costs have risen in direct proportion to the overall inflationary rate of the general economy. This, too, is what MAGNET 77 is about.

For the last three years, through MAGNET, MAG has provided intensive, detailed and practical seminars on how to effectively run the business aspects of your practice. The sessions have been given by Medical Management Consultants who understand your problems and offer solutions. This is information your accountant and attorney cannot give you because they don't have it. What we are providing is essentially a Practice Management Consultation *for you*—the MAG member. This is also what MAGNET is about.

This year's MAGNET Program, controlling costs in the medical practice, is general enough to be of value to business managers, medical assistants, other advisors and most importantly to the physician. At the same time, the Program is specific enough to give you concrete ways to improve your practice, regardless of your specialty.

Broad areas to be covered in the MAGNET Program include: how to analyze your practice's financial situation, what to look for in doing a practice cost evaluation, the cost of equipment and facilities, and collections and insurance and their relationship to costs. Also included will be an in-depth look at various financial systems that you can use to great benefit.

Often we hear, "I don't get anything for my MAG dues money." It just might be that we don't fully utilize what is offered to us.

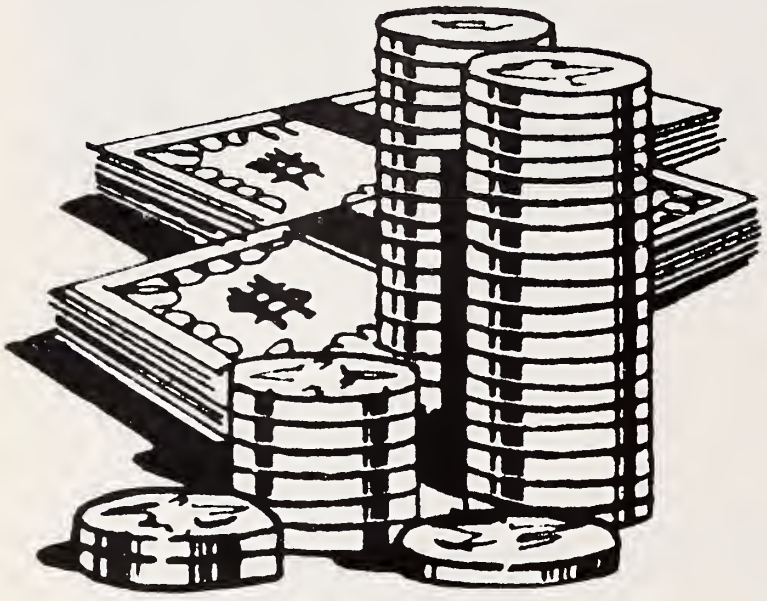
MAGNET is a no-nonsense, practical program designed to help you. The opportunity is there—will you accept it?

Watch for our mailings on Program specifics. Don't miss out.

If you have read the above comments, how can you consider not attending MAGNET 77?

Marvyn D. Cohen, M.D.
Program Chairman
MAGNET 77

Metropolitan Atlanta Study Group



Presents

MONEY MANAGEMENT FOR PROFESSIONALS

Featuring Harvey Sarner, B.S., LL.B.

Author of numerous books, lecturer supreme and Editor of "Sarner and Associates Doctors Newsletter," Mr. Sarner will present realistic suggestions for getting the most out of your insurance and investments and for incurring the least possible federal tax obligation. He is experienced in communicating complex financial ideas to professional people in a way they can understand and apply.

Attendance is limited. Tuition is $95. For brochures and details, contact **Daniel C. Norris, D.D.S., 323 Pat Mell Rd., SE, Marietta, Ga. 30060. Telephone: (404) 436-4141.**

October 28 and 29, 1977 • Northlake Hilton, Atlanta

Variety of Specialties Represented

Guest Educators to Address Scientific Assembly

Atlanta's new favorite gathering spot—the magnificent Omni complex—will provide the setting for high-quality continuing medical education on November 17-20. The occasion is MAG's 1977 Scientific Assembly, featuring scientific sessions of some twenty medical specialty societies.

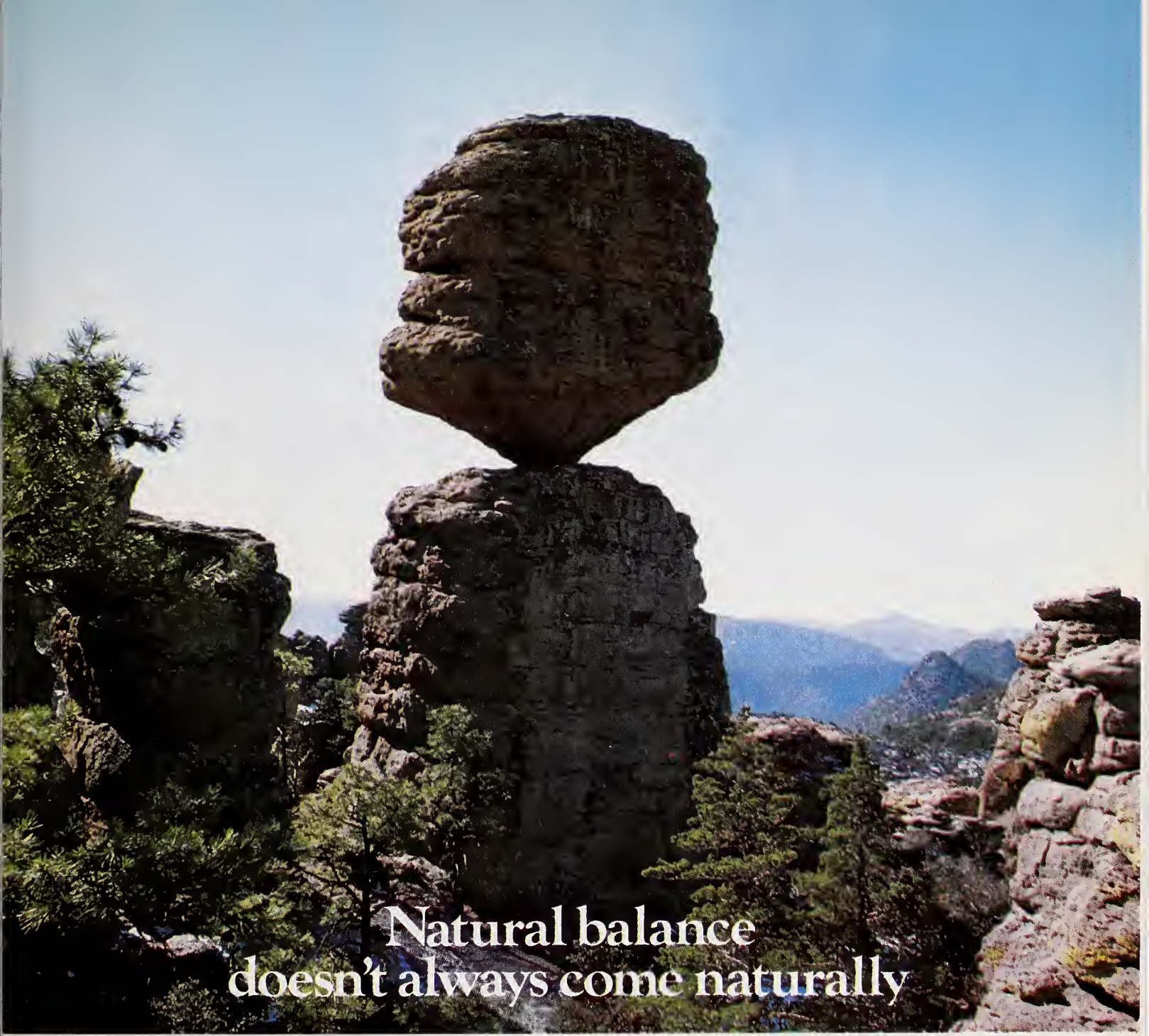
Guest educators for a program on peptic ulcer will be Robert Slaughter from the University of Alabama at Birmingham and James McGuigan of the University of Florida College of Medicine. The program is co-sponsored by the American College of Physicians and the Georgia Gastroenterologic Society.

The program in pathology will feature Jocelyn Hicks and Cheryl Naulty of the Children's Hospital at the National Medical Center in Washington, D.C., and William Enneking of the University of Florida College of Medicine. Directing the annual slide seminar will be Louis Dehner of the University of Minnesota Medical School.

Additional guest faculty includes: Richard Green, Johns Hopkins Hospital, Baltimore (Ophthalmology); Gilbert Campbell, University of Arkansas School of Medicine, and Paul Stevens, Baylor University School of Medicine (Thoracic Trauma); John McGraw, Eastern Virginia Medical School (Plastic Surgery); Henry Marriott, Rogers Heart Foundation, St. Petersburg, Florida (Emergency Medicine); Lawrence Cohen, Yale University School of Medicine (Internal Medicine); Martin Levene, Harvard Medical School (Radiology); William Hunt, Ohio State University School of Medicine (Neurological Surgery), and Harold Ballard, College of Physicians and Surgeons of Columbia University (Public Health).

Speakers for an interdisciplinary program on Asthma were announced on p. of the August *Journal;* two of these speakers will also participate in a program sponsored by the Allergy and Immunology Society of Georgia. The program in Surgery will include symposia on infection and shock in the surgical patient; Pediatrics will be devoted to childhood infections; Neurology will focus on myasthenia gravis, and Psychiatry will take up the topic of psychopharmacology in the aged.

Be sure to check next month's *Journal* for important news about the MAG Luncheon and Calhoun Lecture, the GSIM Luncheon (open to everyone this year), and other special Scientific Assembly events. For registration information, contact Scientific Assembly, MAG, 938 Peachtree St., N.E., Atlanta 30309 (404/876-7535 or INWATS 800-282-0224).



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done, therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

GET MOVING, AMERICA!

It feels good to feel fit
physically, mentally, emotionally.
So learn a skill you can play for life.



Sponsored by
American Alliance for Health, Physical Education and Recreation
1201-16th Street, N.W., Washington, D.C. 20036

AAHPER

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

B.W.CO.® HAS PUT MORE POTENCY IN THE LINE



EMPRACET® with Codeine Phosphate, 60 mg, No. 4 Ⓒ III
EMPRACET® with Codeine Phosphate, 30 mg, No. 3 Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.
WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.
Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.
Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.
Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.
PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.
Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.
ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.
DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing EMPRACET® c̄ CODEINE #4

Each tablet contains: codeine phosphate, 60 mg (1 gr) (Warning—may be habit-forming); and acetaminophen, 300 mg. Ⓒ III

Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet c̄ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet c̄ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet c̄ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® c̄ Codeine #3 provides effective relief of moderate pain.

Burroughs Wellcome Co. makes codeine combination products. You make the choice.

Wellcome | **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

president's letter



HSAs: Danger Lies Ahead

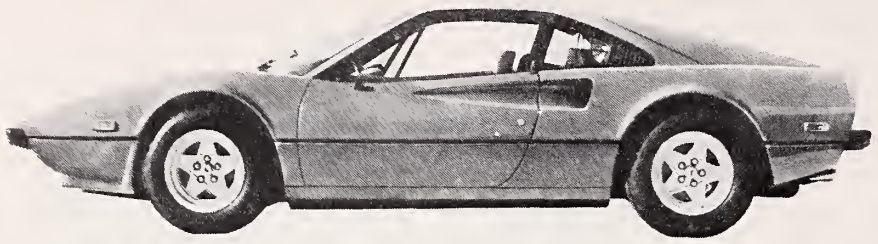
As you know, or should know, one of the most pernicious and insidious of all federal regulatory laws is gearing up for implementation in January. I am referring to the National Health Planning and Resources Development Act (PL93-641). As an association we must make every attempt to keep abreast of the activities of all of the HSAs in the state. The help of all of you is badly needed to inform yourselves and, in turn, your state association of the actions in your respective areas. It may well be that a staff person will be needed to supervise and monitor all of this so that your Board of Directors and Executive Committee can act intelligently to strive for quality medical care for the citizens of the state.

Please forward any pertinent information you may have to the MAG office or to me. We must be vigilant in order to cope with the myriads of problems that will come out of this nefarious legislation.

Sincerely,

Robert E. Perry, M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia



DO ALL DOCTORS DRIVE MERCEDES?

No. Some enjoy the unique experience only a Ferrari delivers.

Driving the 308GTB puts you in an entirely different world of automotive experience. To quote *Autocar*—"All round, one is lost in admiration for the superb quality of the mechanical engineering, the standard of finish of the body and interior details, and the all-round efficiency. It is the best Ferrari we have driven."

Test drive the 308GTB as our guest (it's priced about the same as some Mercedes and Porsche models). Driving will never be the same after you experience Ferrari. You will have known the Ferrari mystique.

faf motorcars inc.

AUTHORIZED FERRARI SALES • SERVICE • PARTS

3862 Stephens Court, Tucker, Ga. 30084 **(404) 939-5464**



Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

I've told this before . . .

(Editor's note: A twinkle in the eye is a dead giveway—after the fact—in this story by Dr. McDaniel. Others wishing to contribute to this page are invite to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

How to Give Your Wife a Pep Shot Without a Needle

ONE SPRING DAY, I came home from a rugged day at the hospital and the office. As I crossed Peachtree Creek going north, the air cooled and I was pleased. I rolled into the back yard and saw my good wife manfully struggling with the hose to get it back on its racks. It was hot and dry and she had been watering the lawn.

We went upstairs to the kitchen together and she looked pretty well worn out. There was perspiration on her forehead, her hair was in disarray and wet, the knees on her pants were wet with soil and she announced at the top of the steps that we were only going to have leftovers for supper. Now this suited me fine, since some of our best meals have been a little of this and that.

I mixed up a small modicum of spirits for the two of us, but that did not seem to pep her up much. She dragged around in the kitchen, warming up the "this and that," and every time she had to bend over she would groan. She was tired.

We had a good meal. I had had two libations of my own mixing and I felt much better than on arrival. I noted that there were only four dishes to wash, two of hers and two of mine. So I got out my apron, marked "Him," turned on the hot water in the sink and asked where the washing powder was. Well, this perked her up. She immediately found it.

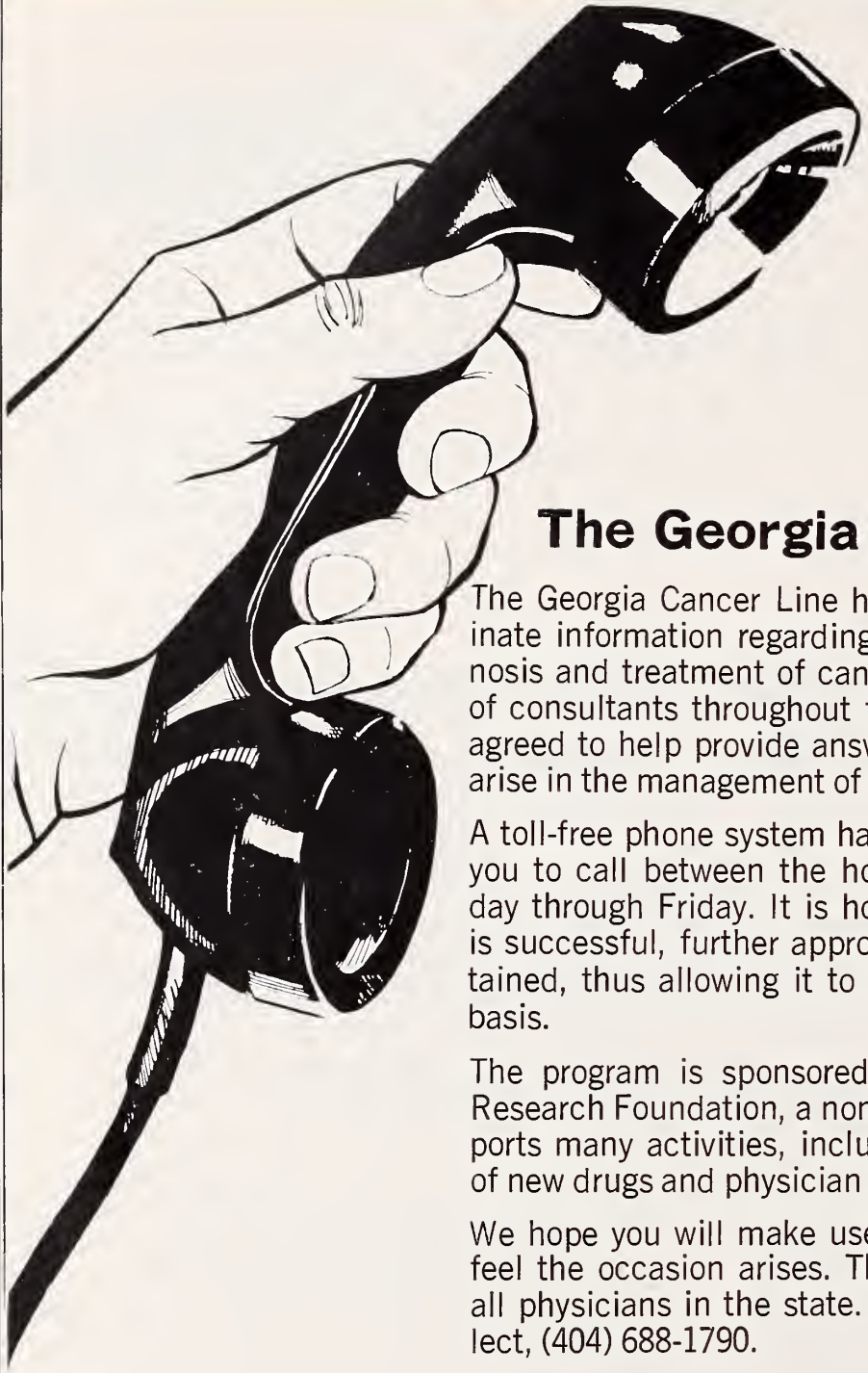
I put these four dishes in the sink, then I commenced getting pots and pans. The patter of feet behind me increased their tempo . . . no more dragging. Then I commenced getting more dishes and more silver and more glasses . . . no time out to groan.

Finally, after about 15 minutes, my back began to hurt and I turned and asked "What in the name of God is coming off here??"

All the weary look was gone now and she answered very sweetly, "Harriett (our daughter) and two friends were here for lunch and I thank you very much!"

I couldn't help but admire a little twinkle in her eye that I had noted off and on for 30 or 40 years when she had outwitted me.

J. G. McDaniel, M.D.
820 W. Wesley Rd., NW
Atlanta, Ga. 30327



The Georgia Cancer Line

The Georgia Cancer Line has been developed to disseminate information regarding recent advances in the diagnosis and treatment of cancer. We have enlisted a group of consultants throughout the state of Georgia who have agreed to help provide answers to questions which might arise in the management of cancer cases.

A toll-free phone system has been set up which will allow you to call between the hours of 9 am and 5 pm, Monday through Friday. It is hoped that if this pilot program is successful, further appropriate sponsorship can be obtained, thus allowing it to be continued on a permanent basis.

The program is sponsored by the Southeastern Cancer Research Foundation, a non-profit organization which supports many activities, including clinical research, testing of new drugs and physician education projects.

We hope you will make use of this system whenever you feel the occasion arises. The Cancer Line is available to all physicians in the state. All you have to do is call collect, (404) 688-1790.

Sponsored by
The Southeastern Cancer Research Foundation
P.O. Box 54777, Atlanta, Ga. 30308
(404) 688-1790

Call Collect

(404) 688-1790

Recent Developments in Cancer Chemotherapy

STANLEY WINOKUR, M.D., *Atlanta**

In the past 20 years, a tremendous change has occurred in our treatment of patients with cancer. We have evolved from primarily a surgically oriented attack to one which utilized a multimodality approach, i.e., surgery, radiation, and chemotherapy. It is this last modality which is undergoing constant change and refinement in an attempt to produce newer and less toxic drugs which can destroy cancer on a microscopic level. In this review I will discuss five new agents which hold great promise in the treatment of patients with cancers of the breast, testicle, bladder, ovary, lung, prostate, and colon.

Cis-Diamminedichloroplatinum (Cis-Platinum) is the first of the inorganic metallic salts which has demonstrated significant antitumor activity in patients with cancers of the testicle, bladder, ovary, and head and neck. It has been extremely active in testicular cancer where it has been incorporated with Vinblastine and Bleomycin to produce remissions in more than 95% of the patients with metastatic disease. In ovarian cancer patients treated with Cis-Platinum alone, the response rate is 25%, but when combined with Adriamycin it has produced tumor regression in 66% of patients. Patients with bladder and head and neck cancers have response rates of 25%.

The major dose limiting toxicities of the drug are gastrointestinal, renal, and audiologic. Nausea and vomiting occur usually within one to two hours of administration and last less than 24 hours. Renal tubular dysfunction can occur; however, this can be minimized with vigorous hydration and diuretics. Auditory abnormalities may occur in 30% of patients. These are usually limited to high frequency hearing loss above the normal range of speech tones.

Estramustine is a conjugate of estradiol-17 beta with an alkylating agent. It was developed because of the need for an effective chemotherapeutic agent with minimal bone marrow toxicity. Cancer of the prostate is a disease which is hormonally sensitive and frequently has extensive bone metastases and replacement of the bone marrow by cancer cells. Many of the patients have received pelvic irradiation which limits their bone marrow reserve through the effects of chemotherapy. Estramustine has demonstrated a 20% objective response and 36% subjective re-

* Member of the Professional Education Committee, American Cancer Society Georgia Division, Inc. and member of the Committee on Cancer, Medical Association of Georgia. Dr. Winoker's address is Suite 400, 315 Boulevard, Atlanta, Ga. 30312.

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society.

sponse in patients with advanced prostatic cancer. It is given orally and has as its only toxicity minimal nausea and occasional gynecomastia. It has been given safely for as long as three years.

Tamoxifen is a nonsteroidal anti-estrogen which has undergone extensive testing in patients with advanced breast cancer. In these patients who have been found to have estrogen receptors in their tumor tissue, Tamoxifen produces remissions in excess of 55%. Unlike the androgens, Tamoxifen has no significant virilizing or fluid retaining side effects. It is given orally usually at a dose of 10 mgs. twice daily. It produces virtually no significant hematologic toxicity.

Hexamethylmelamine is an antitumor agent which has a structure much like an alkylating agent. It has been tested extensively for the past 13 years and has been found to produce remissions of approximately 30% in cancers of the breast, ovary, and lung. It has produced remissions in more than 50% of the patients with lymphoma. Its major toxicity is gastrointestinal; approximately 40% of patients become nauseated. Hematologic toxicity is minimal and is manifested by leukopenia and thrombocytopenia. A small percentage of patients may develop central nervous system toxicity manifested by agitation, depression, and confusion.

Chlorozotocin is the newest of the nitrosourea class of compounds recently released for conical testing. It is chemically related to BCNU, CCNU, and Methyl CCNU which have demonstrated activity in brain tumors, melanoma, lymphomas, and gastrointestinal cancer. The drug has been found to have a marked increase in alkylating activity with virtually no bone marrow suppression. It is given intravenously every six weeks. Its only significant side effect is gastrointestinal toxicity with nausea and vomiting during the first few hours after administration. The drug is presently available for widespread clinical testing and it is hoped that it will provide a significant advantage over the present group of nitrosoureas.

This brief review is meant to familiarize the practicing physician with newer chemotherapeutic agents available in treatment of cancer.

Cobb Society Sponsors Symposium

A Mini-Symposium on "Value Priorities in Our 'Instant' Society; Higher Education—Fact or Myth" will be presented by the Cobb County Medical Society in conjunction with Kennesaw College at Kennesaw College from 9:00 a.m. to 1:00 p.m., on Friday, October 7, 1977. It will be held in the physical education building on Kennesaw College Campus.

The principal speaker will be Dr. John R. Silber, philosopher, distinguished scholar and President of Boston University. Dr. Silber will speak on two topics, "The Pollution of Time—Our 'Instant' Society and How to Live in Time" and "Value Priorities in Higher Education Today."

Serving on panels after these two presentations will be Dr. Fred Davidson, President of The University of Georgia, Dr. Marvin Perry, President of Agnes Scott College, Mr. J. Carrol Dadisman of the *Columbus Inquirer,* Dr. Helen Ridley, Dr. Paul Beacham, Dr. Robert DeMonbreum and Judge Rex Ruff of the Cobb Judicial Court.

There will be no charge for this program since it is financially assisted by the National Endowment for the Humanities through the Georgia Committee on Public Programs for the Humanities. It should be a most exciting and profitable occasion.

Two Set for Georgia—

National Medical Seminars in 38 Cities

The Congress of County Medical Societies, *Private Practice* Magazine and the Private Medical Care Foundation are sponsoring 38 seminars next month, in cities all across the country. The free seminars will not only review existing medical systems, but will outline programs that anyone can complement. They will deal with such topics as: Should private medicine survive in America? What are the administration's plans for NHI? Will Congress pass an NHI bill? Should we follow the British system?

In addition to American doctors, participants include Australian, British and Canadian physicians, U.S. Congressmen, prominent journalists, economics and pharmaceutical experts.

Two seminars are set for Georgia: Atlanta, Downtown Holiday Inn, Tuesday, Oct. 11, 7 p.m.; Augusta, Ramada Inn, Monday, Oct. 10, 7 p.m.



THE PERFECT GET-AWAY PLACE FOR YOU, YOUR FAMILY, YOUR COMPANY.

MOUNTAIN VIEW CONDOMINIUM VILLAS

Lake Arrowhead announces their brand new Mountain View Condominium Villas. These new Lake Arrowhead Condominiums are the most beautiful to be found anywhere—

- Rustic exterior design
- Central heat and airconditioning
- Fully equipped electric kitchen
- Washer/Dryer included
- Wood burning fireplace
- Wall to wall carpeting
- 2-1/2 baths
- Ample inside and outside storage
- Spacious sun deck
- Spectacular mountain view

Prices begin at $46,900

And here's more for you, after a nominal monthly maintenance charge and reasonable amenity fees!

- Membership in the Lake Arrowhead Country Club
- Championship 18 hole golf course
- Tennis and Swim Club
- 500 acre lake perfect for water sports and fishing
- Riding stables and mountain trails
- Picnic and recreational areas

For complete information and or personal inspection appointment call:

Lake Arrowhead Atlanta Office 266-1002

Or use this handy coupon.

Directions: From I-285 to U.S. 19 through Roswell to GA. 140. Once on GA. 140, follow the signs.

From I-75 go north to Roberts Road exit, then right to State Hwy. 5 to Canton, then north (left) on Hwy. 140 thru Waleska and follow the sign to Lake Arrowhead.

Lake Arrowhead is only 56 miles from Atlanta, 43 miles from Rome, 38 miles from Marietta, 21 miles from Cartersville, and 12 miles from Canton.



Yes, I am interested in learning more about Lake Arrowhead's brand new Mountain View Condominium Villas.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

Lake Arrowhead

56 miles north of Atlanta...where a sound opportunity awaits you.

Another Diamondhead Corporation Community

THIS AD DOES NOT CONSTITUTE AN OFFER TO SELL IN ANY STATE WHERE SUCH AN OFFER IS PROHIBITED.

INTERNIST/FAMILY PRACTITIONER: TIRED OF CITY TURMOIL?

Lake Elsinore, which is located only one hour south of Los Angeles and one hour north of San Diego needs you now. The area offers the best of living conditions in one of the most beautiful areas of California.

Due to population growth, we are now in need of two Internists and one Family Practice Physician. We offer excellent guaranteed income for first year with free office space and household move provided. If you want a busy practice away from city pressures, write with C.V. or call:

LAKEVIEW GENERAL HOSPITAL
Chris DiCicco, Administrator
P.O. Box 489
Lake Elsinore, California 92330
Telephone: (714) 674-1421

HICKMAN DATSUN

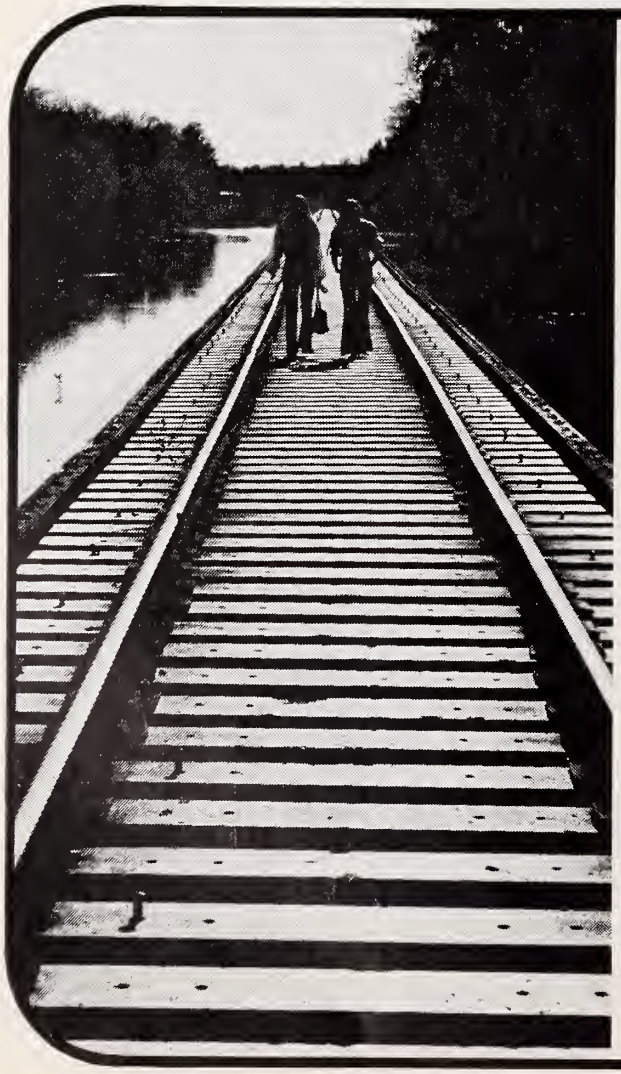
ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD.
2 MILES INSIDE I-285
Phone 455-1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND . . .
We have the South's best service for the whole Datsun Line!



After specializing in the treatment of alcoholism and drug addiction for 17 years, we found . . .

through caring and sharing if you're willing there's a way!

Willingway Hospital

BOX 508 STATESBORO, GA 30458 (912) 764-6236

Accredited by the Joint Commission on Accreditation of Hospitals

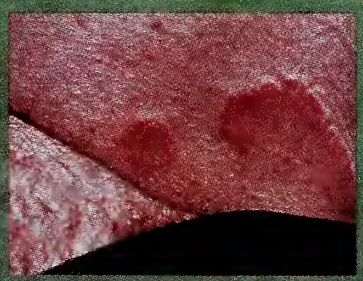
When Griseofulvin is indicated...



TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize)
Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



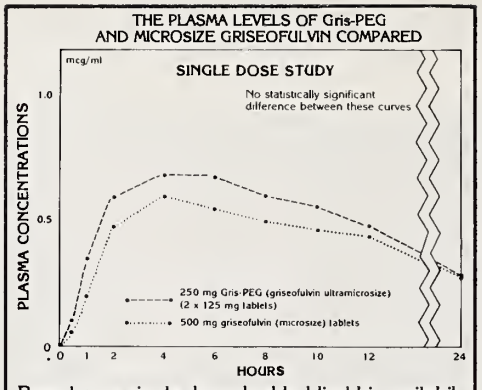
Dorsey LABORATORIES
Division of Sandoz, Inc.
LINCOLN, NEBRASKA 68501

Please see other side for full prescribing information.

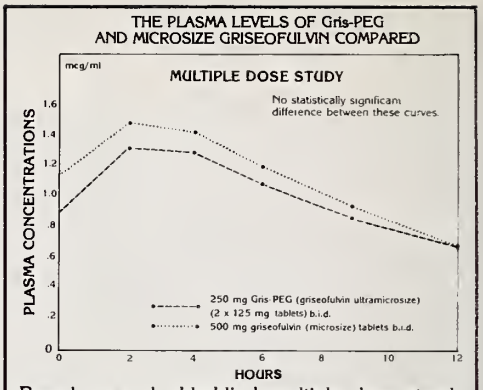
Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

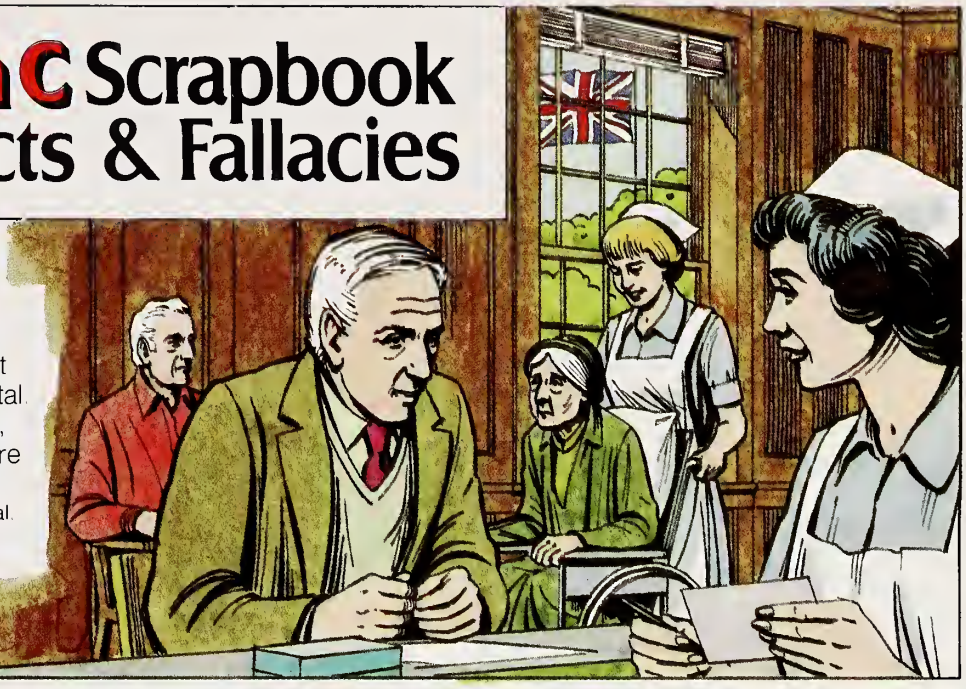
HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

Dorsey LABORATORIES
Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

OY-YB

The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies



A study conducted among elderly patients in England showed that 41% were deficient in ascorbic acid on admission to the hospital. Even among those living at home and well, or not sufficiently ill for admission, 27% were deficient in ascorbic acid.

Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age,* Brit. Med. J., 1:739, 1966.



The loss of riboflavin in milk in a glass container exposed to sunlight for two hours may be as high as 95%.



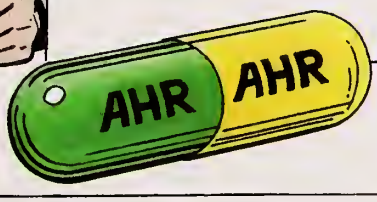
Quick freezing of vegetables is accompanied by very little ascorbic acid loss. But blanching, washing, and prolonged standing at room temperatures results in considerable reduction in Vitamin C content.

In World War I a unit of 100 beds per division in the Russian army was set aside for scurvy patients. Yet, only 20 cases of scurvy were reported among all American troops in 1917-18.





At least 144 different quality assurance tests are run on the raw materials and manufacturing steps that go into Allbee® with C. The Monogram "AHR" on every capsule is your assurance that this is the original and genuine Allbee® with C and not an imitation.



Available on your prescription or recommendation

ALLBEE® with C

High Potency B-Complex and Vitamin C Formula



A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS



Spasm reactor?

Donnatal®!

	each tablet, capsule or 5 ml tsp of elixir (23% alcohol)	each Donnatal No. 2 Tablet
Phenobarbital (warning: may be habit forming)	(¼ gr) 16.2 mg	(½ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

A·H·ROBINS A H Robins Company Richmond Virginia 23220

heart page
heart page
heart page

New Format: Your Participation Is Requested

ROBERT M. PATTON, M.D.*

THE PHYSICIAN EDUCATION COMMITTEE of the Georgia Heart Association has contemplated a change in the format of the Heart Page. In the past, excellent treatises in Cardiology have been disseminated to the membership of the Medical Association of Georgia.

The Heart Page serves several functions. The primary thrust is to offer the practicing clinician current, thorough, useful information to expand his fund of knowledge and provide better care for his patients. Another function is to provide a vehicle for original contributions in cardiology. In order to meet the needs of our Physicians and also provide a forum for someone to publish current thinking in cardiology, the Georgia Heart Association is actively soliciting inquiries from all members from the MAG.

Physicians are urged to seek answers that they feel would help in their medical practice. These could include such topics as:

1. "When do I treat a patient with PVC's?"
2. "How does a primary physician use stress testing?," etc., or
3. Questions relating to the management of a specific patient problem.

Additionally, solicitations are made for anyone interested in publishing a relevant article. A question and answer format will be incorporated as well as short dissertations on selected subjects.

Submission of papers or requests for questions to be answered as well as comments on subjects that are of interest should be directed to: **Robert M. Patton, M.D., 2300 Manchester Rd., Saint Francis Medical Park, Columbus, Ga. 31904.**

* 2300 Manchester Rd., Saint Francis Medical Park, Columbus, Ga. 31904. Articles for this page are prepared at the request of the Committee on Physician Education of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.



CREDITORS MERCANTILE, INC.

Doctors & Hospitals Service Bureau

COLLECTION ACCOUNT CONTROL SYSTEM

Our Professional Collection System Insures:

- Easy Placement of Delinquent Accounts
- Prompt, Regular Follow-up
- Professional Telephone Contacts
- Approved Notices and Letters
- Bonded and Insured Protection
- High Recovery Ratios
- Maintenance of Customer Goodwill

We understand your credit and collection problems.

Established 1914

Charter Member American Collections Association
Member Associated Credit Bureaus, Inc.



4 Executive Park Dr., NE, P.O. Box 95806, Atlanta, Ga. 30347 (404) 321-0999

legal page
legal page
legal page

Informed Consent—Georgia Update

J. WINSTON HUFF, *Atlanta**

In previous issues of the *Journal,* we have discussed the "informed consent doctrine" and its applicability to Georgia physicians. This "doctrine," which has been used as a basis for physician liability in other states, requires that prior to any medical or surgical procedure, the patient be given complete information concerning the procedure and the risks or hazards involved. It is said that the patient has the right to be fully informed so that he may make his own decision before consenting to undergo treatment. This legal principle has served to establish another ground of negligence upon which the physician may be sued. Even though the procedure is performed correctly and skillfully, the physician may be held liable for an unusual or unexpected result if he does not tell the patient that in some cases such a result could happen.[1]

For some years after the informed consent doctrine began to appear in medical malpractice cases in other states, the Georgia courts, when presented with this issue, declined to rule whether or not the informed consent doctrine would be used in Georgia. However, the Georgia Court of Appeals in several cases beginning late in 1975, has rejected the doctrine. A brief reference to these cases may be of interest.

One case, decided in November of 1975, involved a face-lift operation. The lady patient alleged that she would never have consented to the surgery if she had been informed of the possibility of scarring. Her lawsuit sought to apply the informed consent doctrine as it had been used in other states. The court held in favor of the surgeon, based on the Georgia Medical Consent Law.[2] This law, which is discussed below, requires that the physician disclose the "treatment" in "general terms." The court here held that this law pre-empted the doctrine of informed consent in Georgia, that it was a clear expression of legislative intent and that it defined a physician's duty in obtaining a patient's consent. This law, the court said, could not be interpreted to include a disclosure or warning of risks. Since the surgeon had explained to the patient the details of the procedure, he had fulfilled his duty and was not liable.

A later case, decided in 1976, involved a procedure by a thoracic surgeon to treat a nerve impairment. During the operation a motor nerve was damaged causing diminished use of the scapula. The patient sued, charging that the surgeon was negligent in failing to inform him of the danger inherent in a first rib resection. The court held that the informed consent doctrine "is not a viable principle of law in this state."

Another case, decided in 1976, applied the Georgia Medical Consent Law in a

* Prepared at the request of the Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, C & S Bank Building, Atlanta, Ga. 30303.

suit against a hospital. In this case the patient contracted acute hepatitis which he claimed resulted from a hospital-supplied transfusion in connection with an operation. The evidence showed that the surgeon had explained the procedure in detail and had advised the patient of the probable need of a transfusion. The court followed the cases mentioned above and held that the doctrine of informed consent did not apply to the hospital. The court said that the Georgia Medical Consent Law applied to "medical and surgical services" and that there was nothing in this law which restricted its coverage to physicians only. It was pointed out that the hospital had no contact with the patient except through his doctor, and its only act was to supply blood at the doctor's order. The surgeon had explained the procedure to the patient, and the hospital could not be held to any greater duty than the surgeon. Although the Medical Consent Law requires a consent in writing by the patient, the court held that a written consent would not be required where it could be established that the patient knew "from any source" the general course of treatment.[3]

Since these cases turn on the Georgia Medical Consent Law, it might serve well to briefly outline its provisions. This law sets forth first who is authorized to consent to medical treatment. These are:

1. Any adult (now 18 years of age) for himself.
2. Any parent for a minor child.
3. Any person standing legally in place of the parent.
4. Any married person for his or her spouse, regardless of age.
5. Any female, regardless of age, in connection with pregnancy or childbirth, but not in cases of abortion or sterilization.
6. Where no parent is available, an adult for a minor brother or sister.
7. Where no parent is available, any grandparent for a minor grandchild.

The Georgia Medical Consent Law does not extend to a person who has been adjudged incompetent and who cannot therefore give a valid consent.

The law says that in case of an emergency, consent to medical treatment by a physician will be implied. An emergency is defined as a situation where medical treatment is necessary in the judgment of a physician and where a person who may consent is not readily available and a delay in treatment will jeopardize the life or health of the affected person.

The law also provides that a consent to medical or surgical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given and which is duly evidenced in writing signed by the person authorized to consent as described above, shall be "conclusively presumed to be a valid consent" in the absence of fraud or misrepresentation of material facts in obtaining the consent.

The Georgia physician must also be aware that there are several special situations not covered by the Georgia Medical Consent Law. In an abortion procedure after the first trimester, the abortion must be performed in a licensed hospital or facility; and after the second trimester the physician must obtain the concurring judgment of two additional consulting physicians who certify that the abortion is necessary to preserve the life or health of the mother.[4]

A sterilization requires consultation with another physician and a request in writing by the patient. Also, if the person is married, the spouse must consent. The physician must give a full medical explanation concerning the consequences. There is a special provision for sterilization procedures performed on persons who are mentally retarded or brain damaged.[5]

Where a minor professes to have venereal disease or to be suffering from drug abuse, the minor's consent to care and treatment is valid as though the minor were an adult. The treatment must be limited to procedures and therapy relating to these conditions.[6]

The 1977 session of the Georgia General Assembly adopted special provisions relating to consent to treatment of alcoholic or drug-dependent individuals in a

medical emergency; the emergency treatment of a mentally ill individual; and consent to be obtained to treat a mentally retarded individual in an emergency. A physician or his attorney should consult these new laws in these situations.[7]

REFERENCES

1. Approximately 20 states have now enacted statutes defining the informed consent doctrine and delineating the duty of the physician in these situations.
2. Ga. Code of 1933, Pocket Supp. Section 88-2901, *et seq.*
3. I think a physician should still obtain a patient's consent in writing to obviate later difficulties.
4. Ga. Code of 1933, Pocket Supp. Section 26-1201, *et seq.*
5. Ga. Code of 1933, Pocket Supp. Section 84-932, *et seq.*
6. Ga. Code of 1933, Pocket Supp. Section 74-104.2.
7. 1977 Session: Act 372, S.B. 280; Act 373, S.B. 281; Act 374, S.B. 282.

Medical Meeting Calendar

OCTOBER

5-8—*Pine Mountain;* **PSYCHIATRIC INSTITUTE ON GROUP BEHAVIOR AND GROUP LEADERSHIP;** Category 1 Credit; Contact: Associate Dean for CME; Emory University School of Medicine, 69 Butler St., Atlanta 30303, PH: 404/659-1676.

10-14—*Gainesville, FL;* **6th FAMILY PRACTICE REVIEW;** Category 1 Credit; Contact: Mr. Bill Rockwood, Coordinator, University of Florida, Div. of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville, FL, PH: 904/392-3143.

12-13—*Atlanta;* **GEORGIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS, FALL SCIENTIFIC MEETING;** Category 1 Credit; Contact; James W. Bennett, M.D., Program Chairman, 1467 Harper St., Augusta 30902.

13-14—*Atlanta;* **REHABILITATION OF THE PATIENT WITH SENSORY LOSS;** Category 1 Credit; Samuel B. Chyatte, M.D., Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

13-15—*Atlanta;* **AMERICAN SCHOOL HEALTH ASSOCIATION MEETING;** Contact: Mr. Stephen Jerrick, Exec. Dir., P. O. Box 416, Kent, OH 44240.

14-15—*Atlanta;* **RICHARD W. TELINDE SYMPOSIUM ON GYNECOLOGY;** Category 1 Credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., Atlanta 30303, PH: 404/659-1676.

22-23—*Atlanta;* **1977 MAGNET CONFERENCE** (Practice Management); Contact: Mr. Charles B. Templeton, Medical Association of Georgia, 938 Peachtree St., N. E., Atlanta 30309, PH: 404/876-7535 or Toll Free 1-800-282-0224.

28-29—*Atlanta;* **THIRD INTERDISCIPLINARY SYMPOSIUM ON CANCER-RELATED PROBLEMS;** Category 1 Credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., Atlanta 30303; PH: 404/659-1676.

28-29—*Callaway Gardens;* **1977 CME SEMINAR ON INFECTIOUS DISEASES** (for PAs); Contact: Physician Associate Program, Div. of Allied Health Professions, Emory University School of Medicine, P. O. Box 22095, Atlanta 30322.

NOVEMBER

6-9—*Dallas, TX,* **SOUTHERN MEDICAL ASSOCIATION 71ST ANNUAL SCIENTIFIC ASSEMBLY;** Category 1 Credit; Contact: Scientific Assembly, Southern Medical Association, 2601 Highland Ave., Birmingham, AL 35205.

15—*Kingsport, TN;* **PHYSICIANS' CONTINUING EDUCATION SERIES;** Category 1 Credit; Contact: Glen E. Garrison, M.D., Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

17-19—*Atlanta;* **SECOND ANNUAL CONFERENCE ON PHYSICAL IMPAIRMENT AND DISABILITY: "BACK PAIN";** Category 1 Credit; Contact: Mrs. Ethel B. Warner, Center for Rehabilitation Medicine, Emory University, 1441 Clifton Rd., N. E., Atlanta 30322.

17-20—*Atlanta;* **MAG 1977 Scientific Assembly;** Category 1 Credit; Contact: MAG Scientific Assembly, 938 Peachtree St., N. E., Atlanta 30309, PH: 404/876-7535 or INWATS 800-282-0224.

30-Dec. 4—*Atlanta;* **SECOND SOUTHEASTERN CONFERENCE ON ALCOHOL AND DRUG ABUSE** sponsored by Peachford Hospital and Georgia Academy of Family Physicians; Category 1 Credit; Contact: Conway Hunter, Jr., M.D., 2151 Peachford Rd., Atlanta 30341.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

Doctor—Does this sound like your office?

Symptoms:

1. Office personnel bogged down in filling out a variety of insurance forms for private insurers, Medicaid and Medicare;
2. Delays in sending out up-to-date statements to patients;
3. Problems in maintaining and controlling accounts receivable records;
4. Complaints over headaches caused by excess paperwork;
5. Inconvenient and time-consuming filing systems.

Diagnosis:

paperwork nightmare

Treatment:

Relief of all these symptoms can be accomplished with one simple prescription. For a quick

Cure:

Call now for more information.

data med health systems

D M
H S

10510 Clara Dr., Roswell, Georgia 30075
(404) 992-5100

NEW MEMBERS

Adams, William E., Muscogee—Act—NS
P.O. Box 5306, Columbus 31906

Bedingfield, Herbert M., GMS—Act—ORS
601 E. 66th St., Savannah 31405

Copeland, Lanny R., Colquitt—Act—FP
1936 S. Main St., Moultrie 31768

Freid, Norman D., Chattahoochee—Act—ObG
2356 Lenora Church Rd., Snellville 30278

Guerrant, John S., Whitfield-Murray—Act—P
506 Foster Rd., Dalton 30720

Hass, Joseph A., DeKalb—Act—U
Suite 520, 755 Columbia Dr., Decatur 30030

Kumar, Ashok, Muscogee—Act—NEP
Suite 102, Doctors Building, Columbus 31904

Leeb, Dianne Cheryl, DeKalb—Act—PL
Montreal Medical Center, Tucker 30084

Pihl, Bo Gunnar Alfred, DeKalb—Act—PL
Montreal Medical Center, Tucker 30084

Sandvi, M. Aslam, Whitfield-Murray—Act—P
P.O. Box 1168, Hamilton Memorial Hospital, Dalton 30720

Stephenson, John R., Muscogee—Act—ORS
1920 Warm Springs Rd., Columbus 31904

Tracht, Arthur L., DeKalb—Act—ORS
Suite 110, 365 Winn Way, Decatur 30030

PERSONALS

First District

Grace Bautista, M.D., of Hinesville, recently became a Fellow of the American Academy of Pediatrics.

Sixth District

John M. Kellum Jr., M.D., son of **J. Morgan Kellum, M.D.** of Thomaston, has been appointed Assistant Professor of Surgery at Tufts New England Medical Center in Boston.

Seventh District

Lorenzo Cabrera, M.D., of Smyrna, has been elected to Fellowship in the American College of Obstetricians and Gynecologists.

Rome pediatrician, **Eduardo Montana, M.D.,** has been appointed Assistant Clinical Professor of Pediatrics at the Medical College of Georgia, Augusta. Dr. Montana is also an instructor of pediatrics at the Floyd Family Practice Center. He will continue his private practice in Rome.

Ninth District

New Chairman of District IV of the American Academy of Pediatrics is **Martin Smith, M.D.,** who has been practicing at the North Georgia Medical Center for more than 26 years. Dr. Smith's election places him on the executive committee of the Academy with responsibility for Academy activities in seven Southern States and Puerto Rico.

Tenth District

Ta-Jung Lin, M.D., a professor in obstetrics and gynecology at the Medical College of Georgia, Augusta, has been appointed Associate Director of Obstetrics and Gynecology at the Medical Center of Central Georgia. Dr. Linn is internationally renowned for his work in the sub-specialty of reproductive endocrinology and is one of less than 50 certified gynecological endocronologists in the U.S.

DEATHS

John H. Venable

Former head of the Georgia Department of Public Health, John H. Venable, M.D., died July 5 at the age of 68.

A native of Atlanta, Dr. Venable graduated from the Emory University School of Medicine and was a member of the Emory faculty from 1934-1946. In 1946, he became Health Commissioner for Murray and Whitfield Counties and in 1950 became Commissioner of Health for Pike, Spalding and Lamar Counties.

He received a degree in public health from Tulane University in 1951 and took the position of Director of the Georgia Department of Public Health in 1960. In 1972, he left the department to join the staff of the Center for Disease Control in Atlanta. He was made a member of the National Health Resources Advisory Committee in 1966, a position which he held until his death.

Survivors include his wife, Louise Ware Venable, a daughter, a son and a sister.



METROPOLITAN PSYCHIATRIC

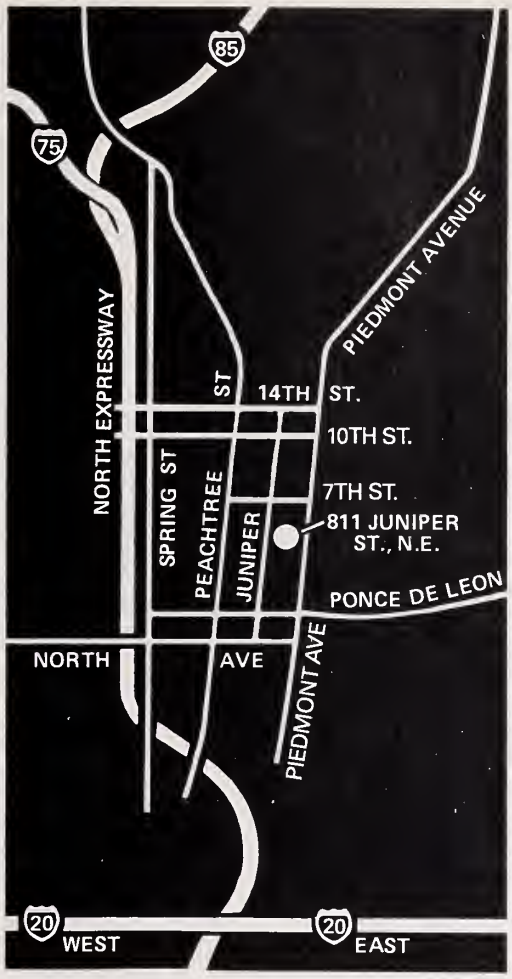
METROPOLITAN PSYCHIATRIC CENTER, centrally located in midtown Atlanta, provides comprehensive services for adult and adolescent patients in the area psychiatry and alcohol and drugs. Inpatient care, outpatient care and partial hospitalization programs available at the Center.

In the Psychiatric Program, the attending psychiatrist determines from the comprehensive services available the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

ily Counseling
hological Testing
al Work Services
ational Tutoring
tional Rehabilitation Counseling
Radiology Services
vity Therapy Programs including Occupational
apy, Recreational Therapy and Art Therapy

eorgian Clinic Program, directed towards the
ry of persons addicted to alcohol or drugs, offers a
red yet personalized experience drawing upon a
nge of treatment modalities. Through the

umet, M.D.
Director

Custis L. Rosser, M.H.A.
Administrator

Dominick, M. Div.
Georgian Clinic Program

combined resources of the Center for Psychotherapy Inc., the Atlanta Internal Medicine, P.A., and the Metropolitan Psychiatric Center staff, the following services are included:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling
- Pastoral Counseling Services

Additional information on the Psychiatric Program may be obtained by contacting Dottie Fitchett, Admissions. For information on the Georgian Clinic Program, call 876-8655. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

litan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
per Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

DOCTOR, LAWYER INDIAN CHIEF

Whatever your profession let us assist in making your home, office (or teepee) a perfect reflection of your taste and needs.

River Interiors is a professional interior design firm with exciting ideas plus practical know-how.

Do you want to spruce your space up a bit? Start fresh from scratch? Or want a new look using pieces you already have? River Interiors can do it with distinction and within your budget.

Interior design improvements are very personal. So we will make house calls to discuss your particular needs----- one professional to another. Consultation without obligation.

Call now for an appointment: 434-0828.

River
interior design

Smyrna, Georgia.

PROFESSIONAL FINANCIAL PLANNING

Who needs it?

One quick test: If your annual income taxes are over $10,000, the chances are that you need to review your financial plan.

Continued inflation and recent tax laws, such as the Tax Reform Act of 1976, provide good reasons for professional evaluation at this time. The services of our firm are available for professional consultation.

M.L. Hines, CFP, President
J.C. Harmon, Vice President
P.G. Renn, CFP, CLU, Vice President

CONSOLIDATED PLANNING CORPORATION
Registered Investment Advisors
148 International Blvd., Suite 801
Atlanta, Georgia 30303
Telephone (404) 659-2920

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word.

FOR SALE PROFESSIONAL PRACTICE (Internal Medicine, Cardiovascular Diseases and Allergy). Established practitioner desires to sell ongoing practice, located in northwest Atlanta. Sale to include leasehold interest in office space, consisting of reception room, business office, private office, two examining rooms, X-ray and development room and laboratory, in addition to all patient files and records, office equipment, complete X-ray laboratory, electrocardiogram equipment and laboratory outfitted for the preparation of drugs for the treatment of allergies. Authorized representatives: Charles D. Menser Jr., Certified Public Accountant and Richard J. Azar Jr., Attorney, 3109 Maple Drive, N.E., Atlanta, Georgia 30305; (404) 233-1989.

NEED A MOUNTAIN VACATION RETREAT where you can hear crickets, frogs and falling leaves? Maybe even snow? Golf, tennis, swim, antique, loaf seriously, ski in season (or peer out at the skiers from the warmth of the log fire in the lodge). Three-bedroom, 2-bath, fully carpeted chalet at Sky Valley, Ga. has dishwasher and Disposall, sleeps 8. Reasonable by day or week. Contact: Dr. Reuel E. Hamilton, Box 311, Marietta, Ga. 30061; telephone (404) 422-7631/1488.

ONE MOBILE RADIOGRAPHIC X-RAY FACILITY in excellent condition for Sale or Lease. Completely self-contained X-ray laboratory, consisting of a 22-foot air conditioned and vandal-protected Winnebago van, condenser discharge X-ray system with tubestand and table, Dupont daylight film loading system, Kodak automatic cold water film processor and all accessories. Very useful for care of nursing home patients, industrial screening examinations, athletic events, or disaster work. Contact Drs. Perilla, Sindler, & Assoc., P.A., 3350 Wilkens Avenue, Baltimore, MD 21229.

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.



Welcome to the 12-month summer

A Sun/Fun enclosed pool stops the calendar at summertime. It makes the climate you want, when you want it.

With a Sun/Fun enclosed pool you can enjoy swimming all year long, day or night, any weather.

You can have more family fun, enjoy spur-of-the-moment parties, get the benefits of invigorating, healthful exercise.

Sun/Fun keeps out rain, sand, wind, insects—makes your pool a year 'round, indoor-outdoor playground for all the family.

Welcome to the 12-Month Summer!

Find out more about enclosing your present or your planned pool. Contact

SUN/FUN POOL ENCLOSURES BY

AQUA-RAMA

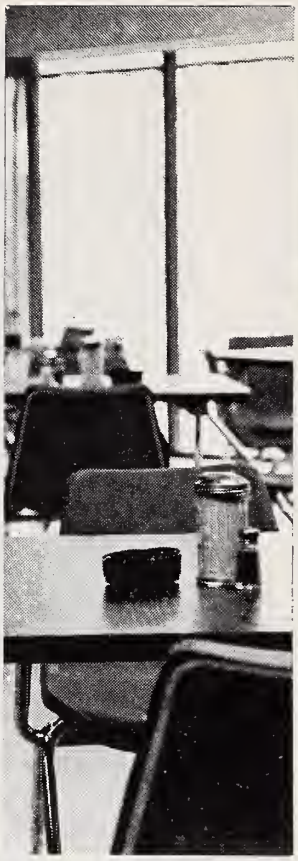
Complete Engineering
And Design Service
Commercial & Residential

Dealer Inquires Invited

Pools & Patio Furnishings
565 Powder Springs St.,
Marietta, Ga. 30064
Phone (404) 422-6291

Visit Our Display.
Write or Phone For Brochure

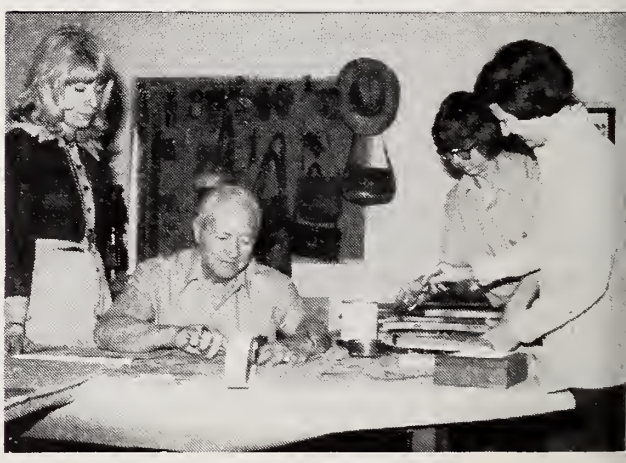




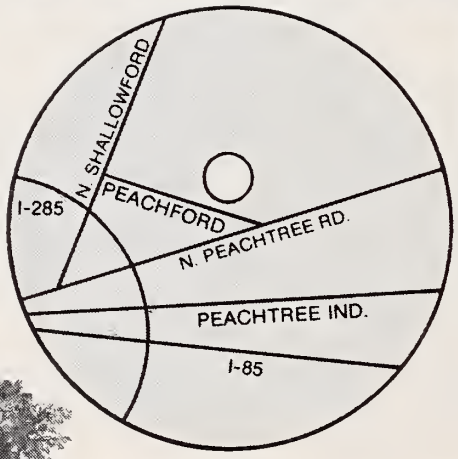


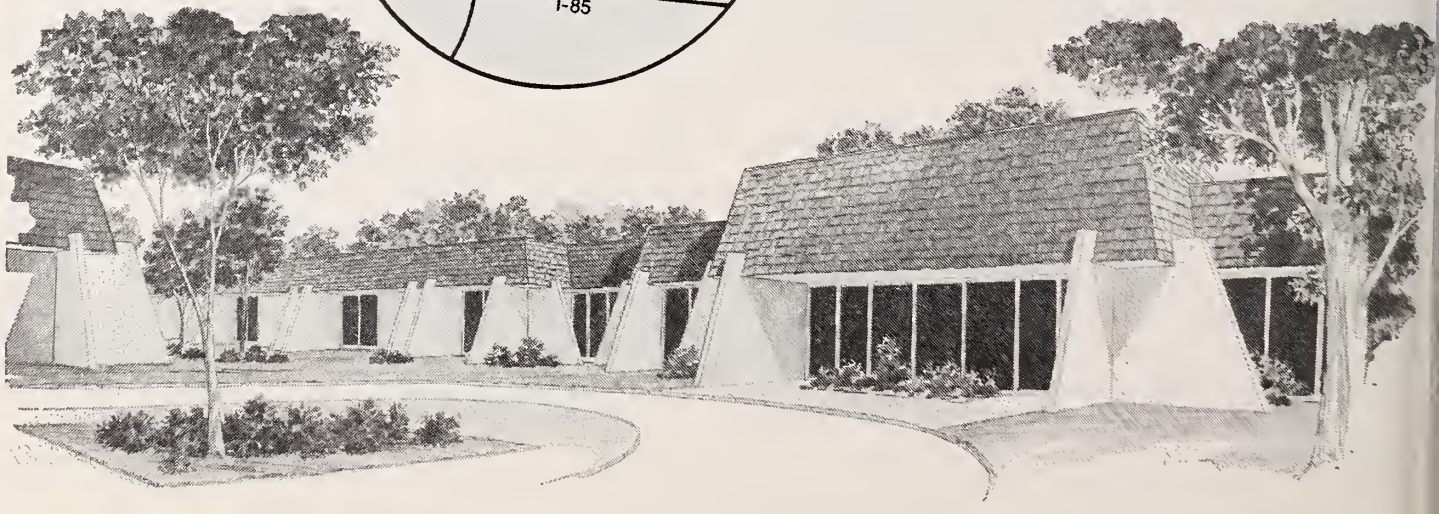






PEACHFORD PERSONNEL PICTURED





PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service
for
Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist
433-2132
2690 Cumberland Parkway
Atlanta, Georgia 30339

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine(	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Menieres Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

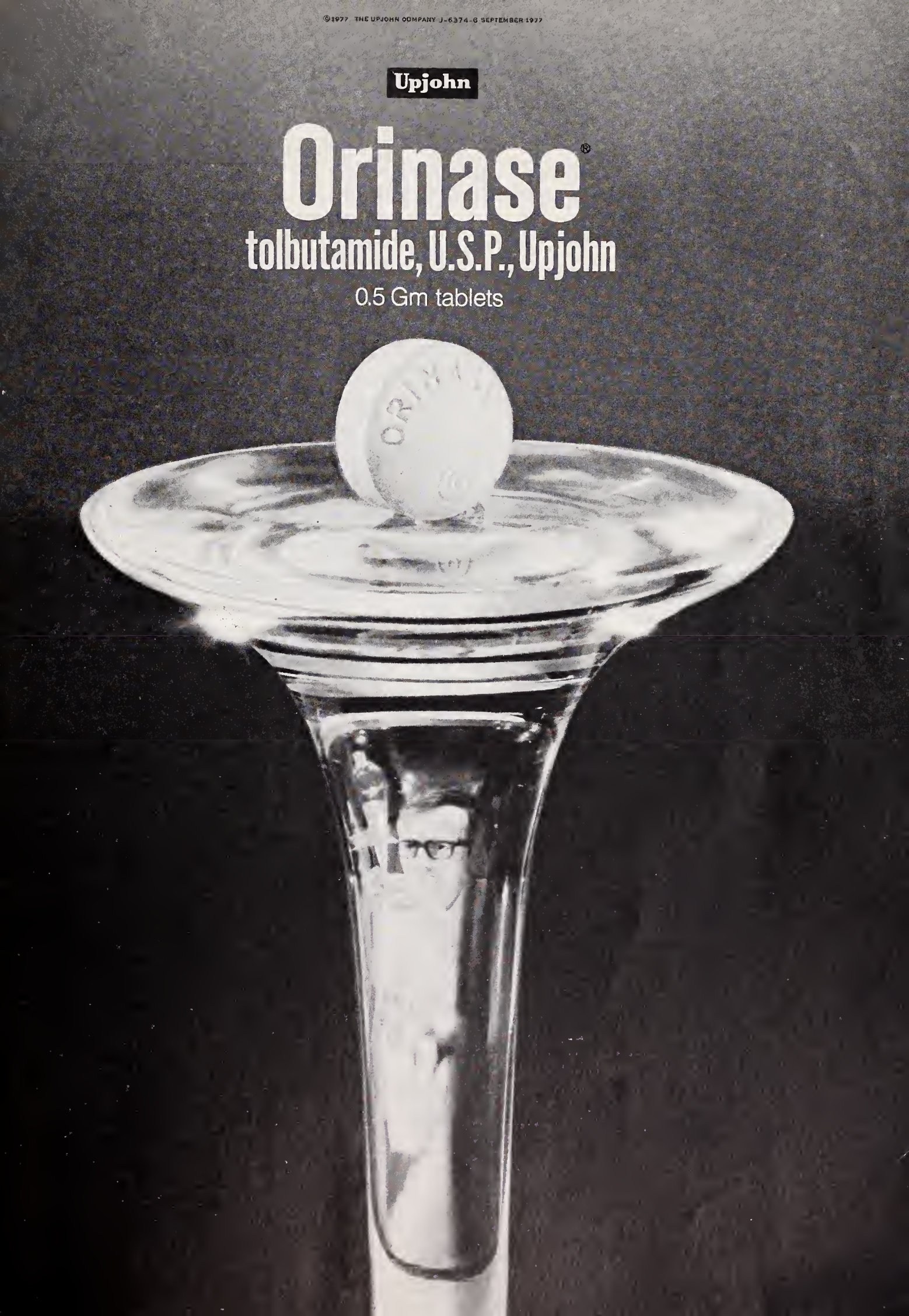
©1977 THE UPJOHN COMPANY J-6374-6 SEPTEMBER 1977

Upjohn

Orinase®

tolbutamide, U.S.P., Upjohn

0.5 Gm tablets



Index to Advertising

Vol. 66 September 1977 No. 9

American Alliance for Health 722
Aqua-Rama 747
Walter Ballard Optical Company 750
Blue Cross and Blue Shield of Georgia/Atlanta 718
Brawner Hospital, Inc. 676
Bugatti Restaurant 695
Burroughs Wellcome Co. 724
Capital Automobile Company 696
Classified Advertising 747
Coca-Cola Company 697
Consolidated Planning Corporation 746
Creditor's Mercantile 738
Data Med Health Systems, Inc. 742
Dickey-Mangham Company 750
Doctors and Hospitals Service Bureau 738
Dorsey Laboratories 733, 734
Duluth Professional Park 685
Eager and Simpson 705
Estes Surgical Supply Company 686
FAF Motorcars, Inc. 726
The French Restaurant 695
Georgia Army National Guard 707
Georgia Cancer Line 728
Hickman Datsun 732
Hill Crest Hospital 678
Hofmann-Kavanaugh 693
Lake Arrowhead 702, 731
Lakeview General Hospital 732
Eli Lilly and Company 680
MAGNET Conference 716
Max' Restaurant 695
Metropolitan Atlanta Study Group 720
Metropolitan Psychiatric Hospital 744, 745
Mimi's Restaurant 695
North Carolina Department of Human Resources 696
Omni International Hotel 695
Ortega Pharmaceutical Company, Inc. 750
Peachford Hospital, Inc. 748, 749
Peachtree and Parkwood Hospitals 706
Physicians Registry 678
Potter-Holden & Company 696
Practice Productivity, Inc. 726
Preferred Partnerships, Inc. 675
Qualicare, Inc. 732
River Interiors 746
A. H. Robins Company 735, 736
Roche Laboratories 674, 753, 754
Roerig 686, 687, 721
Scott Hudgens Properties 685
Smith, Kline & French 723
Squibb & Sons, Inc. 709, 710, 711, 712
Terrace Garden Inn 717
The Upjohn Company 751
U. S. Air Force 679
U. S. Navy 686
Valley Psychiatric Hospital 746
Warner Chilcott 688
Weight Watchers of Greater Atlanta 678
Willingway Hospital 732
1977 MAG Scientific Assembly 694

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.**, 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

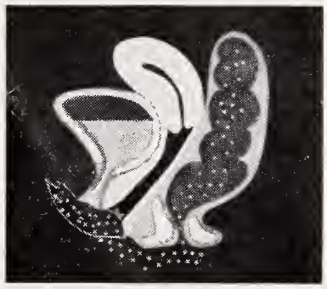
ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days



- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

Her next attack of cystitis may require the Bactrim™ 3-system counterattac



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introi colonization by fecal uropathogens. It has *no* signifi cant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

JOURNAL
of the medical association of
georgia
OCTOBER / 1977

SPECIAL PRACTICE MANAGEMENT ISSUE



1977 MAG SCIENTIFIC ASSEMBLY

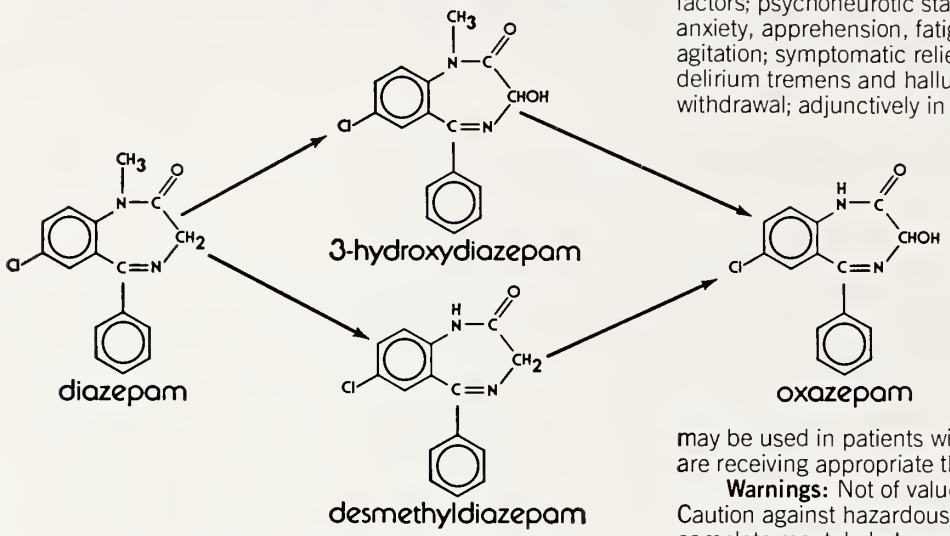
NOVEMBER 17-20
OMNI INTERNATIONAL HOTEL
ATLANTA

PROGRAM INSIDE

MEDICAL ASSOCIATION of GEORGIA
Education Division

LIBRARY
U.C. SAN FRANCISCO
NOV 16 1977

A pharmacokinetic character all its own



Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

This is not a solicitation or an offer to sell or buy any securities. Such an offer is made by prospectus only.

Preferred Partnerships inc.



Re: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Sir;

How much income tax are you now paying? We can help you shelter a portion of your present income---plus show you how you can receive a Tax-Free return.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that give you a better tax write-off. We have investments in the $5,000-$8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

Brawner Hospital, Inc.

Established in 1910
3180 Atlanta Rd.
Smyrna, Ga. 30080
(404) 436-0081



Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 10

EDITOR
Edgar Woody Jr., M.D.
MANAGING EDITOR
Sharon T. Smith
ASSISTANT MANAGING EDITOR
Caffilene Allen
ADVERTISING MANAGER
Mary Coté
BUSINESS MANAGER
L. B. Storey
CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta
PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House
THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Kenneth M. Williams, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant to the Executive Director

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.
Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ASSEMBLY PROGRAM—NOV. 17-20

766 Thursday
766 Friday
767 Calhoun Lecture
769 Saturday
774 Sunday
775 Registration Form

SCIENTIFIC ARTICLES

783 Role of Diet in the Etiology of Colon Cancer
Warren H. Gullen, M.D.

SPECIAL ARTICLES

777 The MAG Disabled Doctors' Program: A Two-Year Review
G. Douglas Talbott, M.D.
A. Cullen Richardson Jr., M.D.
Earnest C. Atkins, M.D.
836 Immediate Evaluation of Athletic Injuries
Allan J. Ryan, M.D.
Fred L. Allman Jr., M.D.

SPECIAL PRACTICE MANAGEMENT SECTION

791 Would a Computer Help Your Practice?
801 Managing Your Time Through Effective Office Practice Scheduling
805 Your Office *Can* Have Good Collections!

EDITORIALS

815 MAG Committee Helps Improve Jail Conditions
John Rhodes Haverty, M.D.
816 Will We Ever Learn?
Jack A. Raines, M.D.

FEATURES

819 President's Letter/MAG Will Help You With PSRO
Robert E. Perry Jr., M.D.
820 I've Told This Before/Horace the Mule
J. G. McDaniel, M.D.
824 Cancer Page/Hormonal Therapy of Breast Cancer
J. Jay Baker, M.D.
829 Legal Page/The Staff Physician's Negligence: When Is the Hospital Liable?
Richard H. Vincent and Charles Stodghill

THE ASSOCIATION

831 New Members
832 Societies
832 Personals
835 Deaths

NEWS

760 Letters to the Editor
775 Scientific Assembly Registration Forms
827 Journal Advertisers
833 Auxiliary Report

THE COVER

The cover features the MAG 1977 Scientific Assembly to be held November 17-20 at the Omni International Hotel in Atlanta. This year, 16 specialties will be represented. For additional information, see pages 765-775.

Letters to the Editor

Dear Sir:

Your excellent publication has earned a reputation for fair and accurate reporting. It was, therefore, disturbing to find an apparent misrepresentation on the editorial page of your July 1977 edition.

You characterized Piedmont Hospital as a "community" facility, which seems counterfactual. Based on reports from members of our Academy, it would appear that Piedmont Hospital denies its services to a broad segment of the community by categorically excluding Family Physicians from its staff.

Contrary to the point of your editorial, such restrictions in hospital privileges perpetuate "allegations that our system of medical care is actually a fragmented non-system."

As you know, the American Medical Association at its San Francisco convention, called for immediate action to eliminate discriminatory policies toward graduates of any residency program. The membership of the Academy calls on Piedmont Hospital to move swiftly in adopting the AMA's recommendation, so that Piedmont might truly be a *community* hospital.

David S. Sowell, M.D.
Vice President
Georgia Academy of Family Physicians

Editor's Note: The above letter was referred to the Chairman of the Board of Trustees and the Administrator of Piedmont Hospital for a response. Their reply follows.—E. W.

Dear Sir:

Piedmont Hospital is proud of its heritage and the broad role that it plays in satisfying the health needs of the community it serves. It is especially gratifying to be recognized in the *Journal of the Medical Association of Georgia.*

In response to the letter by Dr. David Sowell, Vice-President of the Georgia Academy of Family Physicians, Piedmont Hospital does not exclude medical graduates of any Residency program. Article III, Section 2c of the Piedmont Medical Staff Bylaws states:

> "The minimal period of training which will allow a physician to be considered for Medical Staff membership is that required to qualify him as eligible to apply for certification by the specialty board for the appropriate clinical department in which the applicant is applying."

Therefore, all physicians that have completed a Family Practice Residency are eligible to apply for staff privileges at our hospital from the standpoint of training.

Again, thank you for spotlighting Piedmont as one of our many excellent community hospitals.

Hulett D. Sumlin, Administrator
John H. Ridley, M.D., Chairman
Board of Trustees, Piedmont Hospital

Dear Sir:

I congratulate you . . . for the outstanding June "Proceedings" issue which is chock full of vital information. Your cover for that issue was most impressive, and I think some of the changes in the format of the *Journal* have made it more readable and enjoyable.

M. I. Johnson, M.D.
First Vice President, MAG

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

When you're good people recognize you.

Highly effective
Single-dose convenience
Non-staining
Economical
Pleasant tasting

Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

©1977 LONE RANGER T.V., INC.



BREATHING WITH COMFORT.

Choledyl — a highly soluble, true salt of theophylline — rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. *Indications.* Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. *Warning.* Use in pregnancy – animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. *Precautions.* Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. *Adverse Reactions.* Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. *Dosage.* Average adult dosage: Tablets – 200 mg, 4 times a day; Elixir – two teaspoonfuls, 4 times a day. *Supplied.* 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose – 200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir – bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). *Toxicity.* Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL®
(OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT



Lake Arrowhead. A guaranteed 8.6% annual return. And a great resort, too!

Take for example our million dollar Country Club that overlooks the sparkling 500 acre lake. Stretching out behind the Country Club is a magnificent hillside championship golf course, second to none in this entire area. We also have a beautiful Swin and Tennis Club with tournament courts and a huge pool, all waiting for your family.

Where does the guaranteed 8.6% annual return come in? It's made possible by our exciting and revolutionary marketing plan. If you purchase a Lake Arrowhead homesite under this plan, you will receive a guaranteed 8.6% annual return on the annuity premium upon maturity, which **will pay you back the original purchase price you paid for your beautiful Lake Arrowhead homesite and annuity.**

For complete information, call **266-1002** Visit our Atlanta office at 3400 Peachtree Road in the lobby of the Lenox Towers, or use this handy coupon. Remember, this is a limited offer.

Please send me free and complete information about Lake Arrowhead's new marketing concept under which I am guaranteed 8.6% annual return on the annuity.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

AMNG

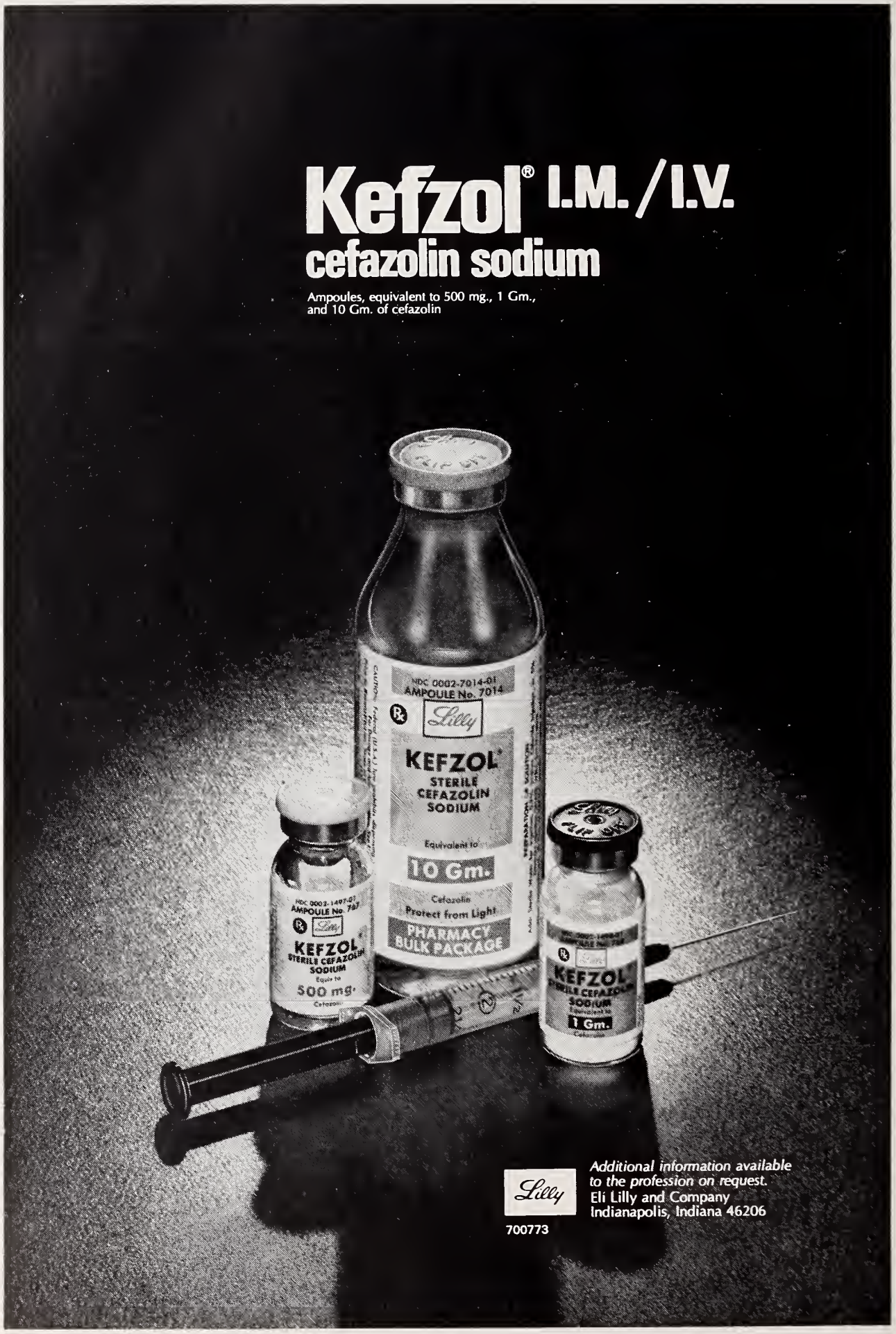
LAKE ARROWHEAD

...where a sound opportunity awaits you.

Obtain the HUD property report from developer and read it before signing anything. HUD neither approves the merits of the offering nor the value, if any, of the property.
This ad does not constitute an offer to sell in any state where such an offer is prohibited.

Kefzol® I.M./I.V.
cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin



Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

700773

JOURNAL
of the medical association of georgia

MAG Annual Scientific Assembly

NOVEMBER 17-20, 1977 • OMNI INTERNATIONAL HOTEL • ATLANTA

THE YEAR 1977 marks the third year of the MAG Scientific Assembly and the second successive year of meeting at the popular Omni International Hotel. Not only has the Omni complex grown this past year in the number of first-rate shopping, dining, and recreational opportunities available, but the MAG scientific program has expanded to include 16 different specialties. Every physician should be able to meet his or her educational needs, and spouses and families will enjoy the Omni's numerous attractions.

Variety of Programs

The 1977 Assembly will open on Thursday, November 17, with an interdisciplinary workshop on the Diagnosis and Management of Asthma, sponsored by the Georgia Lung Association, the Georgia Thoracic Society, the Allergy and Immunology Society of Georgia, and Astra Pharmaceutical Company. A separate $15 registration fee for the workshop includes a working lunch. For workshop registration information, contact the Georgia Lung Association, 1383 Spring Street, Atlanta, Georgia 30309, Tel. (404) 876-3601.

Specialty society scientific sessions will begin on Friday morning and continue to Sunday noon. The MAG Luncheon and annual Calhoun Lecture for all participants, spouses and guests will be on Friday. Featured speaker is G. Timothy Johnson, M.D., TV's "House Call" doctor.

Friday evening will be reserved for special receptions and banquets, including those of the Emory and Medical College of Georgia alumni.

On Saturday, the Georgia Society of Internal Medicine will sponsor a luncheon for all Assembly participants, with an address by Dr. Duncan Neuhauser of the Harvard School of Public Health.

CME Credits

As an organization accredited for continuing medical education, the Medical Association of Georgia certifies that all scientific sessions of the Assembly meet the criteria for AMA Category 1 credit on a one-credit-per-hour basis. In addition, all sessions are acceptable for elective credits by the American Academy of Family Physicians.

Planning Committee

Members of the Planning Committee for the 1977 Scientific Assembly are: Carter Smith Jr., M.D., Chairman; E. Napier Burson Jr., M.D.; LaMar S. McGinnis Jr., M.D.; A. Calhoun Witham, M.D., and Stephen L. Daniel, Ph.D., Coordinator.

Appreciation

The following pharmaceutical firms are thanked for contributing grants and speakers funds for the partial support of scientific programs: Abbott Laboratories; Astra Pharmaceutical Products, Inc.; Bristol Laboratories; Burroughs Wellcome Co.; CIBA Pharmaceutical Co.; Comatic Laboratories; Eli Lilly and Co.; Mead Johnson; Merck Sharp & Dohme; Reed and Carnrick; A. H. Robins Co.; Smith, Kline, and French, and the Upjohn Co.

Registration

Plan now to come to Atlanta the weekend before Thanksgiving for some high-quality, accredited continuing education. Your spouse and family will want to come too to enjoy the many pleasures of the Omni complex. To pre-register, use the form printed on page 775 of this *Journal*. If you wish assistance in coordinating your personal educational program at the Assembly, just write Scientific Assembly, 938 Peachtree Street, Atlanta, Georgia 30309, or call (404) 876-7535.

Hotel Reservations

To make sure you have room reservations for your stay in Atlanta, please fill in the Hotel Reservation Form found on page 775 and mail it to: the Omni International Hotel, One Omni International, Atlanta, Georgia 30303, by November 3, 1977.

THURSDAY MORNING AND AFTERNOON
November 17

Registration 8:00

INTERDISCIPLINARY SCIENTIFIC SESSION

Georgia Lung Association
Georgia Thoracic Society
Allergy and Immunology Society of Georgia

WORKSHOP ON THE PRACTICAL ASPECTS OF THE DIAGNOSIS AND MANAGEMENT OF ASTHMA

8:45
Introduction and Welcome
David G. Tinkelman, M.D.
Program Chairman

9:00
Physiology of Asthma
Elliot F. Ellis, M.D.
State University of New York at Buffalo

10:00
Differential Diagnosis of Wheezing
Raymond G. Slavin, M.D.
St. Louis University School of Medicine

10:30
Coffee Break

10:45
Infections and Asthma
Myron Stein, M.D.
University of California at Los Angeles

11:15
Emotional Aspects of Asthma
David S. Pearlman, M.D.
University of Colorado Medical Center

11:45
Panel Discussion
Alan L. Plummer, M.D., *Moderator*

12:30
Lunch

1:30
Treatment of the Acute Attack
David S. Pearlman, M.D.

2:00
Chronic Management
Elliot F. Ellis, M.D.

2:45
Coffee Break

3:00
Adjunctive Measures in the Chronic Management
Raymond G. Slavin, M.D.

3:30
Management of the Complications
Myron Stein, M.D.

4:00
Panel Discussion
M. Scott Carroll, M.D., *Moderator*

4:30
Acknowledgement and Conclusion
David G. Tinkelman, M.D.

FRIDAY MORNING
November 18

Registration 8:00-12:00

Allergy and Immunology Society of Georgia

CURRENT CONCEPTS IN ALLERGY

8:30
Introduction
M. Scott Scott Carroll, M.D., President
Allergy and Immunology Society of Georgia

8:45
Interesting Case Presentation
William E. Silver, M.D.
Atlanta

9:00
Occupational Asthma
Raymond G. Slavin, M.D.
St. Louis University School of Medicine

10:00
Coffee Break

10:15
The Efficacy of Allergenic Extract Materials and the Rationalization of its Uses in Hyposensitizations.
Elliot F. Ellis, M.D.
State University of New York at Buffalo

11:15
The Pros and Cons of IgE and RAST
Raymond G. Slavin, M.D.

11:45
Business Meeting

American College of Physicians—Georgia
Georgia Gastroenterologic Society

Presiding:
Nicholas E. Davies, M.D.
Governor for Georgia, American College of Physicians

9:00
Welcome
Dr. Davies

9:05
Diverticular Disease of the Colon
Robert Slaughter, M.D.
University of Alabama at Birmingham, School of Medicine

9:35
Extra-Intestinal Manifestations of Crohn's Disease
Robert Slaughter, M.D.

10:05
Activities of the College
Wallace N. Jensen, M.D.
Albany Medical College, Albany, N.Y.
Regent, American College of Physicians

10:15
The Sickle Cell and Illness
Wallace N. Jensen, M.D.

10:40
Coffee Break
11:00
State of the Art: The Newer Gastrointestinal Hormones in Clinical Medicine
James E. McGuigan, M.D.
College of Medicine, University of Florida

Georgia Society of Ophthalmology

CLINICAL PATHOLOGICAL CORRELATION OF EYE DISEASE

8:45
Welcome and Introduction
Clinton D. McCord Jr., M.D., Program Chairman
9:00
Topical Norepinepharine in the Therapy of Open Angle Glaucoma
John F. Bigger, M.D.
9:20
"Little Things Mean a Lot"
Alvin W. North, M.D.
9:40
Thin Membrane Lens and Perma Lens
Louis A. Wilson, M.D.
10:00
Coffee Break
10:15
Ocular Adnexal Pigmentation
W. Richard Green, M.D.
Johns Hopkins Hospital, Baltimore
10:45
"All That Arcs Ain't Glaucoma"
John C. Rieser, M.D.
11:05
Ophthalmic Medications & Intraocular Irrigating Solutions
David S. Hull, M.D.
11:25
Anterior Segment Manifestations of Leukemia
Malcolm N. Luxenberg, M.D.
11:45
Idiopathic Paracentral Retinal Telangiectasis
Bruce Becker, M.D.

American College of Surgeons, Georgia Chapter

9:00
Welcome
Frank L. Wilson, Jr., M.D., President
Georgia Chapter, American College of Surgeons

INFECTION AND THE SURGICAL PATIENT

Morning Moderator: William G. Whitaker, Jr., M.D.
9:15
Antibiotics—Selection, Dose, Distribution, and Mode of Action
Jonas A. Shulman, M.D.
10:00
Septic Shock
Robert Wilson, M.D.
10:45
Peritonitis—Prevention and Treatment
H. Harlan Stone, M.D.
11:30
Discussion—Questions
Drs. Whitaker, Wilson, Shulman, and Stone

Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter

THORACIC TRAUMA AND RELATED TOPICS

Morning Moderator: William A. Speir, M.D.
9:00
Opening Remarks
Alan L. Plummer, M.D.
9:10
Overall Assessment of the Patient with Thoracic Trauma
Gilbert S. Campbell, M.D.
University of Arkansas School of Medicine
10:00
Coffee Break
10:15
The Relationship of Thoracic and Other Trauma to the Adult Respiratory Distress Syndrome
Myron Stein, M.D.
University of California at Los Angeles
10:45
Ventilatory Management of the Patient with Thoracic and Other Trauma
Paul M. Stevens, M.D.
Baylor University School of Medicine, Houston
11:30
Panel Discussion: Drs. Campbell, Stein, and Stevens

Noon—Calhoun Lecture

12:00 Noon Barrington Room



MAG LUNCHEON for Assembly Participants, Spouses, and Guests

1977 Abner W. Calhoun Lecture
"Health Education for the Public—Organized Medicine's Responsibility"

G. Timothy Johnson, M.D.
Harvard Medical School

Dr. Johnson is originator, co-producer, and host of the nationally televised "House Call" TV series; author of the syndicated "House Call" newspaper column; and host and writer of the syndicated TV program "Update on Health." In addition to his medical degree, he holds a Master's Degree from the Harvard School of Public Health. He is a Clinical Instructor in Medicine and Director of Lay Health Information for the Department of Continuing Education at Harvard Medical School and a Clinical Associate in Medicine at Massachusetts General Hospital. In addition, he serves as physician for "Good Morning America" (ABC network) and is author of a book on consumer medical information: *Doctor! What You Should Know About Health Care Before You Call a Physician* (1975).

FRIDAY AFTERNOON
November 18

Registration 2:00-5:00

American College of Physicians—Georgia
Georgia Gastroenterologic Society

THERAPY OF PEPTIC ULCER

2:00
Current Medical Treatment of Peptic Ulcer
James E. McGuigan, M.D.
2:45
Parietal Cell Vagotomy
Eugene Davidson, M.D.
Emory University School of Medicine
3:25
Coffee Break
3:45
Panel: Peptic Ulcer, 1977
Moderator: Zachary Kilpatrick, M.D., Medical College of Georgia
Panel Members: Drs. McGuigan, Slaughter, Davidson, and Julius Wenger
5:30
No-Host Reception
This program is partially funded by a contribution from Smith Kline & French Laboratories.

Georgia Society of Ophthalmology

2:00
Political Guest(s)
To be announced
2:20
Macular Degeneration: Clinical-Pathologic Studies
W. Richard Green, M.D.
3:05
Rhegmatogenous Detachments Related to Chorioretinitis
William S. Hagler, M.D.
Mei Mei Chang, M.D.
3:25
Recent Results of Keratoplasty in Infants
Dwight Cavanaugh, M.D., Ph.D.
3:45
Current Concepts of Retinal Disease
Frank C. Bell, M.D.
4:05
Techniques of Planned Extracapsular Extraction
Harry D. Arnold Jr., M.D.

American College of Surgeons, Georgia Chapter
Afternoon Moderator: Maurice J. Jurkiewicz, M.D.

1:45
Third Annual Residents' Competition for $200 Prize: Four 15-minute selected presentations by surgical residents from the state of Georgia

SHOCK AND THE SURGICAL PATIENT

3:00
Diagnosis, Classification, and Initial Management of Shock
Arlie Mansberger, M.D.
3:45
Pathophysiology, Diagnosis, and Treatment of Shock and Respiratory Failure
Robert Wilson, M.D.
4:30
Prevention of Complications of Shock
H. Harlan Stone, M.D.
5:00
Discussion—Questions
Drs. Jurkiewicz, Mansberger, Wilson, Stone
5:30
Reception

Georgia Thoracic Society and American College of Chest Physicians, Georgia Chapter
Afternoon Moderator: Alan L. Plummer, M.D.

2:00
Traumatic Complications Requiring Surgery
Gilbert S. Campbell, M.D.
2:30
Embolic Disease in the Patient with Trauma
Myron Stein, M.D.
3:00
Prognosis and Determinants of Survival in Severe Respiratory Failure
Paul M. Stevens, M.D.
3:30
Coffee Break

3:45
SYMPOSIUM ON IATROGENIC THORACIC TRAUMA: PRE- AND POSTOPERATIVE RESPIRATORY MANAGEMENT OF THE PATIENT REQUIRING OPEN HEART SURGERY

Preoperative Pulmonary Evaluation and Therapy in the Prevention of Postoperative Complications
Myron Stein, M.D.
Postoperative Respiratory Management: Cardiovascular Surgeon's Viewpoint
Gilbert S. Campbell, M.D.
Postoperative Respiratory Management: Pulmonologist's Viewpoint
Paul M. Stevens, M.D.
(Each speaker will present for 10-15 minutes) Open Discussion Among Speakers and Audience
5:00
Reception and Business Meeting

Georgia Society of Plastic Surgeons

RECONSTRUCTION OF THE BREAST

2:30
Breast Reconstruction Following Modified Radical and Radical Mastectomy
John B. McCraw, M.D.
Assistant Professor of Surgery
Eastern Virginia Medical School, Norfolk
3:15
Subcutaneous Mastectomy
John H. Hartley, M.D.
3:45
One Stage Reconstruction of the Breast Using the Transposed Greater Omentum
Carl R. Hartrampf Jr., M.D.

4:05
Reconstruction of the Nipple
John Bostwick III, M.D.
4:35
Panel Discussion on Problems of Breast Reconstruction
Moderator: Luis O. Vasconez, M.D.
Panel: John B. McCraw, M.D.
S. Angier Wills, M.D.
John H. Hartley, M.D.

Georgia Neurological Society

2:00
THE CURRENT STATUS OF MYASTHENIA GRAVIS
Thomas R. Swift, M.D.
Medical College of Georgia
4:00
Business Meeting
5:00
Reception

American College of Emergency Physicians, Georgia Chapter

EMERGENCY CARDIAC CARE

1:30
Introduction
1:35
Life Threatening Arrhythmias
Henry J. L. Marriott, M.D.
Rogers Heart Foundation,
St. Anthony's Hospital
St. Petersburg, Florida
2:35
Questions and Answers
2:45
Essential and Useful Drugs
Joel M. Felner, M.D.
3:45
Questions and Answers
3:55
Coffee Break
4:10
Acid Base Balance
W. Dallas Hall Jr., M.D.
5:10
Questions and Answers

American Academy of Pediatrics, Georgia Chapter

TREATMENT OF CHILDHOOD INFECTIONS

2:00
Selection of Antibiotics for Critically Ill Children
William E. Feldman, M.D.
2:45
Current Recommendations and Problems in Childhood Immunizations
Alan R. Hinman, M.D.
3:15
Coffee Break
3:30
Selection of Antibiotics for Noncritically Ill Children
Frederick E. Cox, M.D.
4:15
Questions and Answers

Georgia Radiological Society

CANCER OF THE BREAST: DIAGNOSIS AND MANAGEMENT

DIAGNOSIS

1:00
Basic Principles in Interpretation of Mammograms
S. Boyd Eaton, M.D.
1:30
Problems in Interpretations of Mammograms
Jerry B. Buchanan, M.D.
Director of Breast Cancer Detection Demonstration Project, University of Louisville School of Medicine
2:00
The Physical Principles and Exposure Considerations in Mammography
Perry Sprawls Jr., Ph.D.
2:20
Radiographic Modalities of Breast Cancer Detection
Jerry B. Buchanan, M.D.
2:50
Coffee Break
3:10
Mammography-Pathology Correlation
Marjorie B. McSweeney, M.D.
C. Whitaker Sewell, M.D.
3:40
Mammography: Parenchymal Patterns as Risk Predictors
Marjorie B. McSweeney, M.D.
4:00
Detection of Breast Cancer: Contribution of High Risk Factors
Robert L. Egan, M.D.
4:30
Questions and Answers
5:00
Business Meeting—Georgia Radiological Society

SATURDAY MORNING
November 19

Registration 8:00-12:00

Georgia Society of Nuclear Medicine

9:00
Panel: Practical Aspects of Computerization in Nuclear Medicine
10:00
Business Meeting
10:15
DISCUSSION AND PRESENTATION OF NEW REGULATIONS AFFECTING NUCLEAR MEDICINE PRACTICE
Speaker to be announced

Georgia Society of Ophthalmology

9:00
Quantitation of the Marcus Gunn Pupils
Edward M. Fineberg, M.D.
9:20
Superior Oblique Tenectomy for "A" Pattern Strabismus
Zane F. Pollard, M.D.
9:40
The Significance of Macular Holes in Retinal Detachment Surgery
William H. Jarrett, M.D.
10:00
Coffee Break
10:15
Ocular Findings in a Case of Rocky Mountain Spotted Fever
James A. Ehlers, M.D.
10:35
Laser Iridotomy
Thomas S. Harbin Jr., M.D.

10:55
Topic to be Announced
David Campbell, M.D.
11:15
Current Concepts of Oculo Histoplasmosis Syndrome
W. Richard Green, M.D.

Georgia Radiological Society
American College of Surgeons, Georgia Chapter
Georgia Society of Nuclear Medicine

7:00
Breakfast Meeting—Executive Committee, Georgia Chapter, American College of Surgeons

CANCER OF THE BREAST: DIAGNOSIS AND MANAGEMENT

MANAGEMENT

8:30
Breast Cancer in Georgia: Observations on 1,100 Cases Surveyed by the Georgia Cancer Management Network
Robert L. Brown, M.D.
9:00
Breast Cancer: Surgery
R. Waldo Powell, M.D.
9:20
The Role of Radiation Therapy in the Definitive Treatment of Early Breast Cancer
Martin B. Levene, M.D., Deputy Director Joint Center for Radiation Therapy, Harvard Medical School
9:50
Breast Cancer: Chemotherapy, Immunotherapy, and Hormone Manipulation
Melvin R. Moore, M.D.
10:10
Coffee Break
10:30
Breast Cancer: Postoperative Radiation Therapy
Martin B. Levene, M.D.
10:50
Specimen Radiography
Charles Duggan, M.D.
11:10
Breast Cancer: Nuclear Medicine
Oliver Sorsdahl, M.D.
11:30
Screening Mammography: Risk-Benefit Analysis
Jerry B. Buchanan, M.D.
12:00
Questions and Answers
12:30
Luncheon: (See Georgia Society of Internal Medicine Luncheon information, p. 773)

American College of Physicians—Georgia
Presiding:
Arthur J. Merrill Jr., M.D., Program Chairman

8:45
Radioisotopes in Clinical Cardiology
Lawrence S. Cohen, M.D.
Yale University School of Medicine
9:15
Pulmonary Embolus: Something Old, Something New
Nanette K. Wenger, M.D.
Emory University School of Medicine
9:45
Vasodilators in the Management of Congestive Heart Failure
Lawrence S. Cohen, M.D.
10:30
Coffee Break

Presiding:
Robert S. Botnick, M.D., President Georgia Society of Internal Medicine
10:45
Newer Therapeutic Modalities in Rheumatoid Arthritis
Marvin Cohn, M.D.
Crawford W. Long Memorial Hospital
11:15
Physical Activity After Myocardial Infarction: Appropriate and Inappropriate Expectations
Nanette K. Wenger, M.D.
11:45
Business Meeting, American College of Physicians—Georgia
Presiding: Nicholas E. Davies, M.D., Governor
12:30
Luncheon—Georgia Society of Internal Medicine (See GSIM Luncheon Information, p. 773)

Georgia Neurosurgical Society

INTRA- AND POSTOPERATIVE COMPLICATIONS OF NEUROLOGICAL SURGERY

8:45
Introduction and Welcome
William D. Lowery Jr., M.D.
President, Georgia Neurosurgical Society
Morning Session Discussant:
William Hunt, M.D.
Chairman, Department of Neurological Surgery, Ohio State University School of Medicine
9:00
Complications of Lumbar Disc Surgery
Charles Usher Jr., M.D.
Nettleton S. Payne, M.D.
9:45
Choice of Operative Procedure for Cervical Spondylosis
Floyd L. Haar, M.D.
Complications of Anterior Cervical Fusion
Fleming L. Jolley, M.D.
11:45
Summary

Georgia Psychiatric Association

PSYCHOPHARMACOLOGY IN THE AGED

10:00
Theories of Aging: Metabolic Changes
Fred L. Greiner, M.D.
10:20
Psychodynamics: Sociological Aspects of the Aged
F. Conyers Thompson Jr., M.D.
10:40
Coffee Break
11:00
Functional Syndromes in the Elderly
David C. Waggoner, M.D.
11:20
Psychopharmaceuticals in the Aged
DeWitt C. Alfred Jr., M.D.
11:40
Open Discussion

American Association of Public Health Physicians, Georgia Chapter

9:00
Introduction and Welcome
George O. Thomasson, M.D., President
9:05

THE PRACTICAL APPLICATION OF RESEARCH IN THE BLOOD DYSCRASIAS
Harold S. Ballard, M.D.

Introducing...

The Cross-Disciplinary CME Program

For the physician who needs to keep abreast of the latest developments in his own and other specialty areas.



American Medical Association 31st Winter Scientific Meeting
(Formerly the Clinical Convention)
December 10-13, 1977/Miami Beach, Florida

The entire scientific program of the AMA Winter Meeting is specifically designed for physicians who recognize the need for multi-specialty continuing medical education. It offers a broad-based, cross-disciplinary learning experience which is not usually available at specialty society meetings.

And emphasis is placed on the *practical* aspects of new scientific developments—the kind of clinical information that is of immediate application in your practice.

Earn half your CME credits for the year!

The AMA Winter Meeting offers you the opportunity to earn as many as 25 Category 1 credit hours towards the AMA Physician's Recognition Award in one place and at one time. That way you can save yourself time and money by not having to take your CME piecemeal at different times and locations.

Program Highlights

59 Postgraduate Courses—This large selection of Category 1 courses allows you to concentrate on those areas in which you want to update and upgrade your medical knowledge and skills (See overleaf.)

2 Videoclinics, 6 Telecourses, 2 Motion Picture Seminars, 8 State of the Art Lectures, 9 Dialogues—All of these events are Category 1 and free of charge (except the videoclinics). It means you could earn up to 20 hours of Category 1 CME credit *without any cost to you.*

Scientific Exhibits—These presentations highlight research being done in medical schools, hospitals, and research institutes, and provide an ideal one-to-one learning experience.

Industrial Exhibits—More than 80 firms will exhibit an array of new products and services that are indispensable to medical practice.

See overleaf for complete listing of postgraduate courses

Dept of Meeting Services STJ
American Medical Association
535 North Dearborn St.
Chicago, Illinois 60610

Please send me complete information on the AMA 31st Winter Scientific Meeting.

Name _____

Address _____

City/State/Zip _____

Scientific Program

AMA 31st Winter Scientific Meeting

POSTGRADUATE COURSES
Category 1 (fee required)

Basic Electrocardiography
Thyroid Disease: Diagnosis and Management
Evaluation of Coronary Vascular Disease
Advances in Rheumatoid and Collagenous Vascular Disease: Diagnosis and Therapy
Fetal Assessments—Monitoring
Ophthalmology for the Nonophthalmologist
Medical and Surgical Management of Skin Cancer
Basic Life Support—CPR
Fluid and Electrolyte Balance
Hypoglycemia: Diagnosis and Management
Diagnosis and Treatment of Fractures of the Lower Extremities
Medical and Surgical Management of Coronary Vascular Disease
Noninvasive Diagnostic Radiological Techniques
Dermatology for the Nondermatologist
Sports Injuries
Biofeedback and Other Techniques
Clinical Aspects of Immunology
Diabetes: Diagnosis and Management
Psychotropic Drugs: Uses and Abuses
Unsticky Platelets—Loose Clots
Infectious Diseases in Children
Office Gynecology
Drugs: Actions, Reactions, and Interactions
Care of the Critically Ill: Medical and Surgical Management
Office Endocrinology
Newer Clinical Approaches to the Sexually Transmitted Diseases
Diagnosis and Treatment of Fractures, Dislocations, and Epiphyseal Injuries in Children
Advanced Life Support—Cardiopulmonary Resuscitation (CPR)
Medical and Emotional Problems of Aging
Hypercalcemia: Diagnosis and Management
Evaluation and Management of the Jaundiced Patient
Pediatric Feeding and Nutritional Problems
Office Neurology
Psychiatry for the Nonpsychiatrist
Indications for Total Joint Replacement
Management of Acute and Chronic Pulmonary Problems
Evaluation and Management of Hyperlipidemias
Emergency Medicine for 1978
Pediatric Allergy and Immunology
Management of Renal Failure
Management of Hepatic Problems
Diagnosis and Treatment of Fractures of the Upper Extremities
The Integration of Adjuvant Modalities in the Treatment of Cancer
Nephrolithiasis: Diagnosis and Management
Evaluation and Management of Arrhythmias
Current Antibiotic Uses and Abuses
Evaluation and Management of Common GI Problems
Office Orthopedics
Evaluation and Management of Common Urinary Tract Problems
Use and Consequences of Steroids
Exercise Testing and Physical Fitness Proficiency
Advances in Antibiotics and Other Antimicrobials
Evaluation and Management of Seizure Disorders
Evaluation and Management of GI Bleeding
Alcohol and Drug Abuse
Advanced Electrocardiography

SEND IN THIS COUPON FOR COMPLETE INFORMATION ON THE AMA 31st WINTER SCIENTIFIC MEETING

FIRST CLASS
PERMIT No. 1376
CHICAGO, ILL.

BUSINESS REPLY MAIL
No Postage Necessary if Mailed in United States

Postage will be paid by:

Department of Meeting Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Columbia University, College of Physicians and Surgeons

9:35
Panel Discussion

9:50
Questions and Answers

10:05
Break

10:20
Didactic Training
(Speaker and Panel to be Announced)

12:30
Luncheon (See Georgia Society of Internal Medicine Luncheon Information, p. —)

Atlanta Society of Pathologists
Georgia Association of Pathologists
College of American Pathologists

PEDIATRIC CLINICAL CHEMISTRY

9:00
Problems and Methods of Pediatric Sampling. The Pediatric Laboratory's Role in Genetic Screening.
Jocelyn M. Hicks, Ph.D.
Children's Hospital, National Medical Center, Washington, D.C.

10:00
Laboratory Support from a Neonatologist's Viewpoint
Cheryl M. Naulty, M.D.
Children's Hospital, National Medical Center, Washington, D.C.

11:00
Break

11:15
Instrumentation and Methods in Pediatric Laboratory
Jocelyn M. Hicks, Ph.D.

12:15
Questions and Answers

SATURDAY AFTERNOON

Atlanta Society of Pathologists
Georgia Association of Pathologists
College of American Pathologists

SOFT TISSUE SARCOMAS

1:30
Principles of Sarcoma Surgery
William F. Enneking, M.D.
Department of Orthopedics, University of Florida, Gainesville

3:00
Break

3:15
Therapy of Rhabdomyosarcoma as Defined by the Intergroup Study
Abdel H. Ragab, M.D.
Emory University School of Medicine

4:15
Questions and Answers

7:00
Reception and Dinner

Georgia Neurosurgical Society

12:45
Luncheon with Discussion by William Hunt, M.D.

Afternoon Session Discussants:
William Hunt, M.D.
William C. Waters III, M.D.

2:15
Lactic Acidosis and Diabetes Insipidus Following Pituitary Surgery
Ernest C. Fokes, M.D.

Diabetes Insipidus Following Aneurysm Surgery
Richard A. Smith, M.D.

3:00
Inappropriate ADH Syndrome
W. Knox Kinlaw, M.D.

3:45
Coffee Break

4:00
Business Meeting
Presiding: William D. Lowery Jr., M.D.

Georgia Health Care Medical Directors Association

THE PHYSICIAN EXTENDER IN THE LONG-TERM CARE FACILITY

2:00
Introduction
William A. Dodd, M.D.
President, American Health Care Medical Directors Association

2:15
Emory University's PA Training Program for a Nursing Home Role
Robert H. Curry, M.D.
Dennis Balsam, P.A.

Georgia Society of Internal Medicine, Luncheon, 12:30 p.m.

Address: "Cost-Effective Clinical Decision Making"

Duncan Neuhauser, Ph.D.
Health Service Administration
Harvard School of Public Health

Open to all Scientific Assembly attendees and spouses.
100 tickets available on first-come-first-served basis.

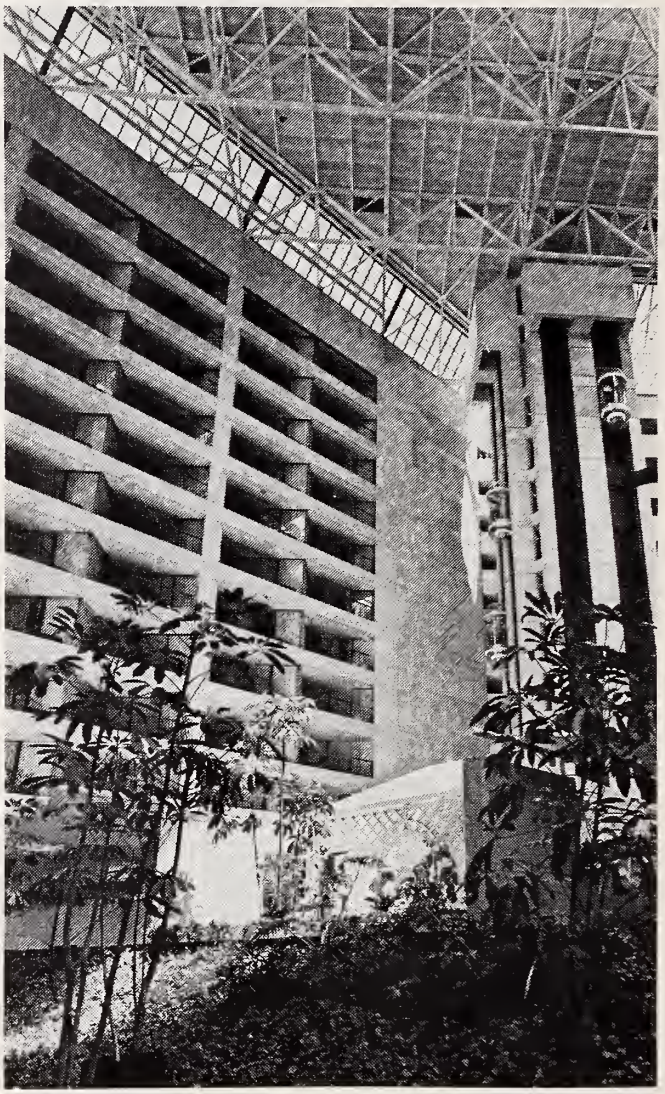
3:00
The Government and Physician Extenders
James W. Alley, M.D.
Director, Division of Physical Health, Georgia Department of Human Resources
3:30
The Nurse Practitioner's Role as Physician Extender
Margaret Chiappinni, R.N.
3:45
Break
4:00
The Nursing Home Administrator and Physician Extenders
Mr. Gernald A. Bishop
Nursing Home Administrator, Smyrna
4:30
Round Table Discussion: How Nursing Home Physicians Use Physician Extenders to Improve the Quality of Care
Moderator: George E. Artress, M.D., President, Georgia Health Care Medical Directors Association
Panel: William A. Dodd, M.D.
Joseph A. Hertell, M.D.
Robert L. Pyle, P.A.
Ronald T. Gresham, P.A.
John Schmidt, P.A.

SUNDAY November 20

Atlanta Society of Pathologists
Georgia Association of Pathologists
College of American Pathologists

PEDIATRIC PATHOLOGY

9:00
Annual Slide Seminar
Louis P. Dehner, M.D.
University of Minnesota Medical School, Minneapolis
10:30
Break
10:45
Annual Slide Seminar (Continued)
Louis P. Dehner, M.D.



The Omni International Hotel

Make your plans now to attend the biggest MAG Scientific Assembly ever. To register for programs of your choice, fill out the top form on the opposite page and send it to MAG Headquarters. Hotel reservations can be made by filling out the bottom form and mailing it to the Omni International Hotel.

Special luncheons will be held on Friday and Saturday. For details, see pages 767 and 773, respectively.

MEDICAL ASSOCIATION OF GEORGIA
Education Division

REGISTRATION FORM

1977 MAG SCIENTIFIC ASSEMBLY **November 17-20, Omni International Hotel, Atlanta**

NAME: _____

ADDRESS: _____

_____

Please check appropriate boxes:

Registration Fee and Tickets

☐ Member, Medical Association of Georgia	$15.00
☐ Visiting Physician	25.00
☐ Intern or Resident	(no fee)
☐ Physician Assistant, Allied Health Professional, or Nurse	10.00
☐ Interdisciplinary Workshop on Asthma, Thursday (includes lunch ticket)	15.00
☐ MAG Luncheon, Friday Number attending _____ Tickets:	8.00 each
☐ GSIM Luncheon, Saturday Open to all Physicians and Spouses Number attending _____ Tickets:	10.00 each

To order slides for Pediatric Pathology Seminar:

☐ Slides only	25.00
☐ Slides for registered participants (slides will be mailed in advance of meeting)	15.00

Enclosed is my check to the Medical Association of Georgia for _____

Important: (Please check appropriate boxes)

I plan to attend the Scientific program(s) sponsored by:

- ☐ Allergy and Immunology Society of Georgia
- ☐ American Academy of Pediatrics, Georgia Chapter
- ☐ American Association of Public Health Physicians, Georgia Chapter
- ☐ American College of Emergency Physicians, Georgia Chapter
- ☐ American College of Physicians — Georgia
- ☐ American College of Surgeons, Georgia Chapter
- ☐ Georgia Gastroenterologic Society
- ☐ Georgia Health Care Medical Directors Association
- ☐ **Georgia Lung Association, etc. (Interdisciplinary Asthma Workshop)**
- ☐ Georgia Neurological Society
- ☐ Georgia Neurosurgical Society
- ☐ Georgia Psychiatric Association
- ☐ Georgia Radiological Society
- ☐ Georgia Society of Internal Medicine
- ☐ Georgia Society of Ophthalmology
- ☐ Georgia Society of Pathologists
- ☐ Georgia Society of Plastic Surgery
- ☐ Georgia Thoracic Society

MAG will help you coordinate your personal CME program — Phone (404) 876-7535 or WATS 800-282-0224

Clip and Mail to: MAG Scientific Assembly
938 Peachtree Street, N. E.
Atlanta, Georgia 30309

1977 MAG Scientific Assembly
Hotel Reservation Form

Name .....

Address .....

City .....

Company ..... **Telephone** .....

Sharing room with .....

Method of Payment ..... **Credit Card No.** .....

Arrival Date .....

Arrival Time ..... **Guaranteed** ☐

Reservations will be held until 6:00 p.m. unless guaranteed or covered by deposit.

Length of stay ..... **nights.**

Reservations received after 11-3-77 will be accepted on space available basis.

Please circle type of accommodations desired:

Single	**$36.00**
Double	**$44.00**

Send Hotel Registration to: Omni International Hotel,
One Omni International,
Atlanta, Ga. 30303.

Linde
MEDICAL OXYGEN SERVICE, INC.
WALKER
DISTRIBUTOR

New Oxygen Therapy Systems for Home Use

- Pulmonary Care Unit
- Oxygen Walker System

Dependability in Home Care Services

- scheduled, periodic visits
- up-to-date records
- emergency service twenty-four hours a day
- patient training in use of equipment
- broad range of equipment and services

Service Centers

- Atlanta
- Albany
- Waycross
- Serving all points in between

WE SELL SERVICE

- Additional literature upon request.
- 935 Jefferson Street, N.W. • Atlanta, Georgia • (404) 875-4058

A review of this vital Program, including an analysis of its objectives and a description of the treatment process

The MAG Disabled Doctors' Program: A Two-Year Review

G. DOUGLAS TALBOTT, M.D., A. CULLEN RICHARDSON JR., M.D. *and* EARNEST C. ATKINS, M.D., *Atlanta**

THE PUBLIC HAS ONLY recently been made aware, via the lay press, of the hazards presented by physicians who continue to practice despite serious impairment due to abuse of alcohol or other drugs. The American Medical Association conservatively estimates that one of every ten certified doctors is thus impaired. The great majority of these sick physicians deny their disease and persist in their professional activities. This has been possible because of a combination of circumstances.

First of all, denial is an outstanding characteristic of the addictive diseases. Augmenting denial is the myth of physician-invincibility, purposely inculcated in medical school and usually an integral part of the practicing physician's personality—a conviction that "it can't happen to me!" Today's physician lives in a drinking culture and feels obliged to maintain the standards of that culture. Furthermore, he has access to a wide spectrum of mood-changing drugs, and daily, almost hourly, faces stresses which tempt him to accept convenient chemical relief. Another strong factor in denial is the ancient attitude of our society which regards alcoholism or any other addiction as evidence of moral weakness and reason for social ostracism; few status-conscious members of the medical profession would readily admit such stigma.

Perhaps the most important circumstance of all is the "conspiracy of silence," intended benevolently, which has effectively prevented family, friends, and professional colleagues from openly recognizing the disabled doctor's disease, and has tragically delayed both diagnosis and treatment. Thus professional pride has killed many physicians. That conspiracy of silence can be broken only by a vigorous educational campaign, conducted among both laity and health professionals. Members of medical groups and their families must be made aware that alcoholism and other addictive diseases and most psychiatric disorders are *treatable* diseases, not moral weaknesses and not synonymous with social disgrace; that true kindness lies in bringing such sickness to treatment, not in efforts at concealment; and that disabled doctors, as a professional group, show a much higher than average recovery rate after adequate treatment.

"Adequate treatment" is the principal stumbling block. Treatment obviously waits on identification, and comparatively few of our 50 states have emerged from the era of the "conspiracy of silence." The AMA Council on Mental Health voiced its concern a few years ago and recommended that each State or County Medical Society appoint a committee to "take cognizance of a physician's inability to practice, to assess his condition, and to advise his treatment."[1]

Georgia, with an estimated 500 of its 5,000 licensed physicians disabled at any given time, became one of the first few states to follow this recommendation. Since then, it has become the first state to become actively involved in the treatment of the disabled doctor, and to provide him with a special place for treatment of members of the medical profession, should he so choose.

The purpose of this paper is to currently review the Disabled Doctors' Plan in Georgia, and to bring

* Dr. Talbott is Program Chairman of the Disabled Doctors' Program and Program Director of the Alcohol and Drug Program at Ridgeview Institute, 3995 South Cobb Dr., Smyrna, Ga. 30081. Dr. Richardson is Chairman of the Disabled Doctors' Committee; Dr. Atkins is Secretary of the Medical Association of Georgia.

this *Journal*'s readership up-to-date on the results and the current functioning of the state program.

Organization of the Plan, Reviewed

The Disabled Doctors' Plan in Georgia was initiated in September of 1975, after months of study, planning, and a vigorous educational campaign, under the sponsorship of the DeKalb County Medical Society. The objective and mechanisms of the Plan were described in this *Journal* soon thereafter.[2] At that time, the term "Disabled Doctor," as used in Georgia, applied only to those physicians whose disability arose from abuse of, or addiction to, alcohol and/or other chemicals.

Time and experience have contributed to a progressive evolution of the Plan. We will describe here the elements of the Plan as it currently operates, distinguishing between the old and the new.

Our Program has been expanded to include doctors disabled by psychiatric disorders. Surprisingly, these patients have responded very well to the general outlines of the treatment offered for the addictive diseases, with the addition of more attention from the psychiatrist, on a one-to-one basis, and the administration of psychotropic drugs in isolated instances.

We have maintained our original premises: (1) The disabled doctor, for reasons discussed elsewhere,[3,4] is generally unable to seek help spontaneously. (2) Therefore, his professional peers have the obligation of taking the initiative in bringing him to voluntary treatment; any doctor who has recovered from such a disability has a special obligation toward (and a special effectiveness in helping) other doctors afflicted with the same disease. (3) Any plan to aid the disabled doctor must be under the aegis of the State Medical Society, for only then can it be uniformly applied, and only when thus potentially linked with the State Board of Medical Examiners can it be powerful enough to limit (or in some instances prohibit) the practice of those who consistently refuse treatment, refuse to complete treatment, or fail to recover sufficiently after treatment.

Our objectives remain unchanged:

1. To identify and verify the disabled doctor, protecting his anonymity and causing him as little embarrassment as possible;
2. To motivate him to voluntarily enter treatment;
3. To assume an advocacy role on his behalf;
4. To aid him in re-entering professional activities after adequate treatment;
5. To provide a means of protecting his patients, his medical community, his family and the doctor himself from the consequences of non-treatment, incomplete treatment, or failure of treatment.

The implementation of the Plan was first carried out by two committees; now there are three.

The Physicians' Consultant Committee (PCC) continues with its original functions and responsibilities, which include all voluntary aspects of the program, from verifying the identity of the disabled doctor to maintaining supportive contact as he completes the re-entry process. The PCC is responsible to the Disabled Doctors' Committee which is also the Professional Conduct and Ethics Committee of the State Medical Society.

"Members of medical groups and their families must be made aware that addictive diseases are treatable . . . (they are) not moral weaknesses and not synonymous with social disgrace"

The DDC for the Disabled Doctors' Plan still consists of the regular members of the State Medical Society's Ethics Committee, plus two addictionologists. This body considers individual cases brought to its attention by the PCC, and decides whether or not any specific case should be brought to the attention of the Executive Committee because of refusal of treatment, failure to abide by treatment contract, or failure to improve sufficiently after a reasonable period of treatment.

The Executive Committee has final decision as to whether any case is to be brought to the attention of the State Board of Medical Examiners. Following the lines of administrative responsibility, as outlined, the recommendations of the Executive Committee are usually accepted by the Board of Medical Examiners, which controls licensure.

New Facilities, Modalities, and Personnel

A great step forward was taken when the State Medical Society accepted responsibility for substantially funding the Disabled Doctors' Plan, as of June 1, 1977. This financial support has immeasurably strengthened our program. Members of the three committees still freely contribute their time and effort, outside the demands of their own professional duties. In addition, we are now able to have a full-time Program Coordinator for Medical Auxiliaries, and a place which is dedicated to the intensive treatment and care of disabled doctors.

Caduceus Hall, a facility of Ridgeview Institute, designed primarily for the residential treatment of disabled doctors, was formally opened for that pur-

pose on March 1, 1977. It has a 30-bed capacity and adequate space for individual counselling, group counselling, AA meetings and other assemblies. Its location permits easy access to other mental health treatment facilities on the campus of Ridgeview Institute, and is adjacent to a full accredited community general hospital. Caduceus Hall provides headquarters space for the Disabled Doctors' Plan of Georgia.

The Caduceus Club was established during the winter of 1976-77, originally with the intention of providing a focus for fellowship and social activities for alumni and staff of the Disabled Doctors' Plan and their families. It has gone beyond its first purpose and has come to have considerable value not only as an educational and therapeutic modality but also as an instrument for aftercare. Doctors in treatment and their families or significant others attend as guests, and become full-fledged members on completion of treatment.

In response to requests of both alumni and doctors in treatment, we have recently arranged for closed meetings prior to the general meeting of the Club. Here under the leadership of a male and a female therapist, separate therapy groups are held for the addict and the spouse. Individuals are free to present their own problems for discussion. The format of the regular meeting is entirely informal. A leader is named each week for the following week. At the leader's pleasure, the meeting may be patterned after a typical AA meeting, may consist of one or more talks on some quality such as "honesty," followed by group discussion, or may be devoted to some aspect of addiction, or mental health, or coping mechanisms; the possibilities seem infinite. Members of the Caduceus Club tend to remain in touch, and to return for special meetings after all requirements have been fulfilled—even though they may live in remote parts of the state.

During the first 18 months of operation, the Program was able to return recovered physicians to their medical practices at the rate of one per month. As of September 1, 1977, 62% of the doctors who entered treatment have returned to practice

We have already mentioned expanded membership of the PCC. This, too, came about in answer to a need. Since the Disabled Doctors' Plan has become better known throughout Georgia, it has become difficult for the original 13 members of the PCC, travelling in pairs as prescribed, to visit all the disabled doctors who are brought to the committee's attention, without considerable hardship and neglect of their personal responsibilities. We have found it both expedient and therapeutically useful to augment the original PCC with selected "graduates" of the Program. Currently the PCC consists of 17 members, with the likelihood of further growth, as need may dictate. The original ratio of recovered physicians to addictionologists remains as we are practicing the concept of the formerly-ill serving others who have the same disease.

A full-time medical director was appointed on June 1 of this year. In addition to routine medical duties at Caduceus Hall, he is responsible for coordinating the work of the PCC, making sure that their reports reach the DDC, and that contracts with incoming patients are properly signed. The medical director is also responsible for after-care; he visits each former patient in the patient's own professional setting at least once during the last phase of treatment, or re-entry period, and initiates telephone contact at least once a month during those months. He is on call day or night, when in town, for emergency counselling and for medical service.

Newly established also, as of June 1, is the office of Program Coordinator for Medical Auxiliaries. This requires visiting each medical auxiliary in the State of Georgia at least once during the year, responding to requests for talks on addiction, mental health, the Disabled Doctors' Plan, and the treatment services available. This coordinator is also co-leader of the Spouse Group which meets weekly at Caduceus Hall.

Still serving in a voluntary capacity is the program director, who was responsible for the inception of the Plan and who coordinates all the facets of the Disabled Doctors' Program. He works in coordination with the medical director and the chairman of the Disabled Doctors' Committee and serves as chairman of the Physician's Consultant Committee.

Steps in the Treatment Program

After a disabled doctor has been identified and verified, he is visited by a team of two PCC members, usually selected because they have no prior acquaintance with him. The PCC team announce their advocacy status and explain the Disabled Doctors' Plan. They make as many visits as necessary, within reason, to encourage their subject to enter treatment voluntarily. They report the outcome of their efforts to the medical director and the program director who reports to the DCC.

When the disabled doctor has agreed to enter treatment, he is obliged to sign a treatment contract with the Disabled Doctors' Plan, as represented by a member from each of the three committees. This contract, which is first thoroughly discussed with

both the doctor and his spouse, is not legally binding, but it does express moral obligation and honest intent on both sides. If any of its terms are broken by the doctor, the DDC must be notified; at the discretion of that group the matter may be brought to the attention of the Executive Committee of the State Medical Society for disposition.

The contract specifies four phases of treatment and the term of each, as follows:

Phase I—One month at a qualified residential treatment center of the patient's choice, anywhere within the United States, preceded (only if appropriate) by a period of in-hospital detoxification.

Phase II—One month as an out-patient at DeKalb Addiction Clinic; out-of-town patients stay at a half-way house maintained exclusively for disabled doctors.

Phase III—Two months in physician's apprenticeship, helping to care for patients with addictive diseases or psychiatric disorders, at such facilities as those of the Salvation Army, Georgia Mental Health Institute, or Caduceus Hall. Near the end of the first of these two months, phased re-entry to the patient's former professional activities is begun. During the second of these two months, increasing periods of time are spent in his former professional setting, under the supervision of the PCC team, the Medical Director and the Program Director.

Phase IV—Eight months of professional activity in the area of the recovering doctor's choice.

This totals a minimum of 12 months. Individual circumstances may require lengthening of any given phase or phases.

The disabled doctor pledges to attend AA meetings and Caduceus Club meetings regularly and to abstain from all mood-changing drugs, including alcohol, unless specifically prescribed by the attending physician, for the full term of his treatment.

The contract also provides space to write in any individual requirements or restrictions.

Among the residential treatment centers chosen to date by disabled doctors for the first phase of their treatment are Willingway, Metropolitan, Chit-Chat Farms, Hazelden, Smithers, and the recently opened Caduceus Hall.

A second year of supervision is provided under voluntary agreement by the Medical Director, with attendance at the weekly Caduceus Club meetings and individual contacts with members of the PCC.

Residential Treatment at Caduceus Hall

Since Caduceus Hall is newly established, we consider it appropriate to briefly describe the types of treatment currently offered there.

Medical Approach: Detoxification is usually done in the Hall over a five-day period, but when necessary, complicated cases can be transferred to the adjacent general hospital, where our medical staff has privileges. Each patient is given a thorough physical examination on admission to Caduceus Hall, and a careful medical history is taken. Existing medical problems are evaluated, and treated as circumstances indicate; consultants are called in as necessary. All addictive disease patients have baseline psychiatric and psychological consultations and evaluations. Physical conditioning is begun, with attention to both diet and appropriate regimen of exercise.

Educational Approach: This includes imparting information about the disease of addiction and the community resources available for fighting it. It includes an examination of present attitudes—of the individual, his family, his community in general and his professional peers. We begin the inculcation of positive attitudes.

Psychotherapy: Both individual and group insight therapy are used. Chemical-trigger mechanisms are explored. It is worth repeating that, in our experience to date, doctors disabled by psychiatric disorders have responded well to our general program. with the additions already mentioned.

Family Therapy: This consists of Couples or Spouse Groups, Family Unit Groups (spouse, parents, and children), and Significant Others Groups, each meeting under the leadership of a specially trained therapist.

Instruction and Supervised Practice in Coping: The emphasis here is on meeting life's anxieties, disappointments, and loneliness without chemical support. Individuals are guided in confronting their own fears, exploring their own unrealized strengths and potentials, and in constructive involvement with persons and things outside themselves. Individually innovative ways are sought to relieve depression and to build self-confidence without resorting to chemicals. Peer group review is held on each patient.

Alcoholics Anonymous and Affiliates: AA meetings are held each week. From the first day of admission, attendance at these meetings plus two outside AA meetings each week is required. The work of Al-Anon, Al-Ateen, Al-Atot, and Al-Fam, as well as Narcotics Anonymous, is explained. Family attendance at the appropriate affiliate is strongly urged.

Spiritual Retraining: A non-denominational worship is conducted each Sunday morning at Caduceus Hall under the leadership of a trained cleric addictionologist. Staff, alumni, and patients are invited to attend. It is our belief that a well-nourished spirit promotes a healthy body and mind.

Results to Date Expressed Numerically

The following figures were taken from a report on the Disabled Doctors' Plan as of September 1, 1977, after the first 24 months:

Number of disabled doctors contacted and verified		**64**
Number who entered treatment		**47**
Number who broke contracts	**3**	
Currently in treatment	**15**	
Deceased	**1**	
Returned to practice	**29**	
Repeating treatment	**5**	

During the first 18 months of operation, the Plan was able to return recovered physicians to their medical practice on the average of one per month.

The Lessons of Experience

Since the Georgia Plan may serve as a prototype for those in other states who are devising programs to help the disabled doctor, it may be helpful to summarize some of the lessons we have either newly learned or else confirmed during the two years of our operation.

1. Any effective plan for disabled doctors must be under the aegis of the State Medical Society. This assures the same power and authority which has made industry's efforts in the rehabilitation of alcoholics more successful, on the average, than programs which are not related to family economics.

2. There must be a positive relationship with the State Board of Licensure (at the end of a chain of command which safeguards the rights of the individual physician), to protect patients, the integrity of the medical community, and even the doctor himself, if he refuses to accept or complete voluntary treatment.

3. The program must be planned to deal effectively with denial, lack of motivation for treatment, and repeated relapses. All three of these problems are characteristic of the disease of addiction, and are especially pronounced in members of the medical profession.

4. There must be an effective outreach program, supported by an energetic plan of education regarding the disease concept of alcoholism and other addictions and of psychiatric disorders.

5. The recovering physician must become involved in the treatment of others with his own disease.

6. All those responsible for the implementation of the program must be imbued with the philosophy of advocacy, rather than a primitive approach.

7. All pertinent support systems (family, colleagues, local medical society, the appropriate hospital administrator, pastor, and others) must be positively involved in the patient's recovery.

8. The concept of peer group therapy must be implemented in every possible situation.

9. Treatment must be long-term, phased over a minimum of four months' acute care and continuing for at least eight months thereafter with a second year of support-supervision. One or more relapses will obviously increase the period of treatment required.

10. There must be provision for informal aftercare, friendly contact, and occasional emotional support for an indefinite time after treatment is formally ended or for as long as the recovering doctor chooses to use it.

REFERENCES

1. AMA Council on Mental Health: "The Sick Physician. Impairment by Psychiatric Disorders, Including Alcoholism and Drug Dependence." *JAMA* 223:684-687, 1973.
2. Talbott, G. D., Holderfield, H., Shoemaker, K. E. and Atkins, E. C.: "The Disabled Doctors' Plan for Georgia." *JMAG* 65:71-76, 1976.
3. Talbott, G. D., Shoemaker, K. E., Follo, M. L. and Bullard, A. L.: "Some Dynamics of Addiction Among Physicians." *JMAG* 65:77-81, 1976.
4. Talbott, G. D.: "The Disabled Doctors Program of Georgia. *Alc. Clin. Exp. Res.* 1:143-146, 1977.

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972



PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD
Mental Health Center and Hospitals
1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431
Accredited by the Joint Commission on Accreditation of Hospitals

Role of Diet in the Etiology of Colon Cancer

WARREN H. GULLEN, M.D., M.P.H., F.A.P.H.A., *Augusta**

THE ETIOLOGY OF CANCER of the colon is, for the most part, unknown. Two uncommon conditions that are widely accepted as being precursors of colon cancer are ulcerative colitis and *familial* polyposis of the colon. Other more common conditions have been implicated but are less clearly precancerous. Haenszel and others associate polyps and adenomas with the occurrence of carcinoma, either as the locus or as concomitant lesions. Even if such benign neoplasms could be shown to be precancerous, there still remains the question as to the etiology of cancer both in persons with such pre-existing disease and in those without. In the last several years, a number of theories have been articulated which relate dietary factors to the occurrence of the cancer. These theories are based on a variety of types of epidemiologic evidence. Most of the more noteworthy of these are discussed below.

Even though many dietary factors have been implicated, the jury is far from in on these intriguing questions.

Geographical Differences in Food Consumption Compared to Rates of Colon Cancer

Between Countries

Some investigators have examined vital statistics and other data and claim that there is apparently a world-wide correlation of colon cancer and coronary disease (in which diet has also been implicated). Unfortunately, the quality of some of these data leaves much to be desired.

Certain differences in colonic carcinoma incidence do appear to be real, even allowing for differences in quality of data and other factors. For instance, the incidence seems to be relatively high in Europe, North America, and Australia and relatively low in Asia, Central and South America, and Africa.

In particular, the rate of colon cancer is much lower in Japan than in the United States. However, the difference does not extend to the lower rectum for which the rates are about equal. It is interesting to note that the average intake of saturated fats is much lower in Japan as compared to the U. S. It is also of note that second generation Japanese in the United States have a significantly higher colon cancer rate than exists in Japan. And these Americans of Japanese descent have a higher average fat intake and higher serum cholesterol than the "Japanese" Japanese.

There have been a few multi-country comparisons (e.g., by Gregor in 1969) that indicate a possible association between the cancer and the level of animal protein ingestion.

Some have indicted food additives as etiologic agents. The relevant data are sparse and not too supportive. For instance, Denmark has a relatively high rate of colon cancer but allows little in the way of food additives.

The evidentiary waters are quite muddy. As an example, consider Argentina which has an apparent rate of colon cancer that is relatively high along with a high intake of meat, but a *low* intake of refined carbohydrates and an apparently *low* incidence of atherosclerosis.

A comparison in 1969 of colon cancer rates and Food and Agricultural Organization data on available dietary fiber in various countries failed to reveal a significant correlation. However, Burkitt compared Africa to the U. S. and the United Kingdom and noted a difference in both colon cancer incidence (high in U. K. and U. S. and low in sub-Sahara Africa) and consumption of unrefined and refined carbohydrates (unrefined high in Africa, low in U. K. and U. S.; refined low in Africa, high in U. K. and U. S.). He also claims a concomitant and similar difference in the rates of diverticulosis, hiatus hernia, and a few other diseases. His rationale linking the excess of refined or deficiency of unrefined dietary carbohydrate in America and England with their higher rates of colon cancer involves several

* Associate Professor and Chief, Epidemiology and Biostatistics Subsection, Community Medicine Section, Department of Family Practice, School of Medicine, Medical College of Georgia, Augusta, Ga. 30902.

This paper was presented at the Twelfth Annual Rural Health Conference sponsored by the MAG, the Georgia Farm Bureau and the Georgia Cooperative Extension Service, Macon, Georgia, August 25, 1976.

factors. First, the stool transit time is much shorter in Africa (he studied the Bantus among others). Also, the stool consistency is much different. As compared to the Bantus (who frequently give themselves enemas if they don't have several movements a day), the Americans and Englishmen are essentially all constipated. The frequency of bowel movements and the short transit times among the Africans (the difference in transit times having been confirmed by the use of dietary markers) supposedly lessen the amount of bile degradation by stool flora into potential carcinogens and lessen the time that such metabolites remain in contact with colonic epithelium. It should be noted, however, that the fibers generally available to Africans differ from those generally available in the West so that mere increase in "Western" fibers would not yield a diet the same as that of the Bantus and other Africans of that general region.

Within the U. S.

There are several differences that are notable within the U. S. A study of Jews in New York revealed a comparatively high risk of colon cancer but the excess risk did not appear for carcinoma of the rectum.

One group whose disease patterns have been of interest in various ways is the Seventh Day Adventists. A study of Seventh Day Adventists in California revealed a low intake of meat, low serum cholesterols, low intake of saturated fats, and a low risk of cancer of the colon.

Alaskan Eskimos, on the other hand, run a relatively high risk of colon cancer. They eat quite a bit of meat but little refined carbohydrates. And they are not particularly affluent. So colon cancer is not just a "disease of affluence" (whatever that means).

Within Other Countries

The data on such comparisons are sparse and the quality is sometimes doubtful. However, it is interesting to note that Northern India has a higher average fiber intake than Southern India, but Northern India has a colon cancer rate about 10% higher than that for Southern India. In addition, one notes that little of the substances we think of as food additives are used in either part of India.

Secular Trends

A frequently powerful epidemiological tool is the observation of trends in disease patterns over time.

Multicountry

Gregor, et al., investigated the secular trends in 23 countries and found an apparent time correlation between the increase in colon cancer mortality rates and the consumption of animal protein. Also, while (as previously stated) the colon cancer rate in Japan is quite low, it has been slowly increasing. At the same time, there has been an increase in the proportion of indigenous Japanese who consume a "Westernized" diet.

In the U. S.

The Americans of Japanese descent in Hawaii have exhibited an increased risk of colon cancer over a period of years. This change in risk has been apparent mainly with respect to the colon exclusive of the rectum.

Likewise, Hawaiians descended from Chinese from Singapore have suffered an increase in risk while Chinese still in Singapore show no such change.

In the U. S., there was a marked increase in the colon cancer rate in the first several decades of this century. This observation resulted from several large-scale cancer incidence surveys conducted over a space of several years by the National Cancer Institute. The last such survey was conducted in 1969-71 and the previous one was performed in the late 40's. A comparison of the results of these last two surveys reveals some noteworthy changes. The overall incidence, as already stated, increased. In the previous survey, the blacks had a markedly lower rate in both the North and South while the latest survey showed that, while Southern blacks still have a lower rate than Southern whites, Northern blacks now have an incidence slightly (but not significantly) in excess of that for Northern whites. Could this be a reflection of greater changes in diet among Northern blacks who may be eating foods more similar to those consumed by the whites? In addition, in both surveys and for both races the colon cancer incidence was higher in the North than in the South. While Southerners have experienced an increase in colon cancer rate, they are still at an advantage as compared to Northerners with the blacks at a greater advantage than the whites. Of course, there have been tremendous changes in the South in the past few years (there seems to be a homogenization of cultural patterns throughout the U. S.) and it is difficult to know to what extent the described differences still hold although such factors usually require considerable time to affect chronic disease patterns. Finally, it should be pointed out that the last two N.C.I. surveys indicated a shift in pathologic patterns with an increase in cancer of the colon and a decrease in cancer of the rectum—colon cancer is no longer primarily a disease of the rectum and that fact has implications with respect to diagnosis and case finding.

Case-Control Studies Within Populations

Case-control studies consist of comparisons in diet patterns between groups of people with colon cancer and groups of people without colon cancer (frequently those hospitalized for other reasons). It is difficult

to tell exactly how many such studies have been done since it appears that essentially the same study may sometimes be published in several journals in slightly altered form. The case-control studies in regard to colon cancer have not tended to yield consistent, significant diet differences with the notable exception of the study by Haenszel and Berg.

Correa investigated this disease in Cali, Colombia and claimed that there was an association of colon cancer with the consumption of *lean* beef. In Tel Aviv, Modan found a lower fiber intake among cases of colon cancer as compared to the controls. This difference held for the colon but not the rectum.

Wynder, et al., reported in 1969 on a study in results from studies by Stocks, Pernu, and Higginson, and in 1967 they conducted a study of 791 case-control pairs in New York City and were also unable to demonstrate significant differences in diet patterns.

Wynder, et al, reported in 1969 on a study in Japan of 157 colon cancer patients and 307 controls. They found no consistent significant differences but they did note a higher fat intake (and higher socioeconomic level) among the cases. There was no significant difference found for serum cholesterol, incidence of other medical or surgical problems, or alcohol or tobacco usage.

Migrant Case-Control Studies

When one is studying the effects of environmental variables (such as diet), a particularly powerful tool is the study of migrant populations (i.e., persons who are natives of one country or place but move to another). In such populations, the people tend to take on (with various speeds) the cultural practices of the host country or place and thus to change the environmental exposures.

Haenszel and Berg studied Japanese immigrants into Hawaii (Issei) and their offspring (Nisei or first-generation Japanese-Americans). For each group, they compared colon cancer cases with controls (members of the group but without colon cancer). The cases ate more "Western" diets, more starches, and, particularly, more meats and legumes. When the data were further dissected, the main positive effects were related to the consumption of beef and string beans (which are *high* in fiber!). No relationship could be shown for the intake of eggs, dairy products, and other so-called "cholesterol foods." Also, no significant effect of fiber could be shown. There was no difference in the intake of preserved pork as compared to fresh and there was no demonstrable association of colon cancer with intake of dried or salted fish (which would tend to cast doubt on the possible role of nitrates and nitrosamines). Their findings do tend to favor an environmental (diet) hypothesis over a genetic hypothesis. If the relationship to beef consumption is causal, it is not certain what in the meat is the agent since beef contains large amounts of fat and other substances as well as protein.

Prospective Studies

Studies in which people with and without a suspected etiologic factor are followed to determine the incidence of the disease in the various groups are called prospective studies and are ordinarily considered more definitive than case-control studies (for a variety of reasons). They are also more expensive, time-consuming, and difficult to execute. There have been very few done on the subject at hand.

Hammond and Horn in their famous American Cancer Society study of lung cancer (and other diseases) versus tobacco consumption, included in their questionnaire a few questions about diet (along with smoking history). They could show no association between the answers to the diet questions and the subsequent incidence of colon cancer. There is a moderately large prospective study underway in 10,000 Japanese Hawaiians.

Colon Biochemistry and Flora

There has been quite a bit of work done in this area but, since it concerns pathogenesis more than the etiologic role of diet, we will consider it only briefly.

Both observational and experimental evidence indicate that diet (fat, fiber, etc.) changes the intestinal flora. Diet also changes the biochemical composition of the stool. In particular, it has been observed that populations with a high rate of colon cancer (e.g., U. K.) also tend to have more stool anerobes and a greater degree of degradation of bile salts. The implications are intriguing but not conclusive.

Animal Studies

In animals, investigators have achieved or observed an elevated rate of colon cancer with increased presence of bile components, anerobic microorganisms, and/or high fat diet. Again, this is interesting but not conclusive and may or may not be extrapolatable to people.

Miscellaneous

Mixed results have been obtained from studies of the relationship between obesity and incidence of cancer of the colon and rectum.

Summary—Main Hypotheses

There is moderate evidence to implicate the intake of fats, especially saturated fats.

With regard to dietary cholesterol, the findings are very mixed.

The evidence with respect to animal protein is of moderate strength. However, the measures of consumption of animal protein may be confounded with the intake of animal fat since they frequently are consumed together.

One of the most popular current theories concerns the role of fiber (or lack thereof). The evidence is questionable and consists mainly of cross-cultural differences with all their difficulties in interpretation. Also, there seems to be a problem concerning the definition of fiber (in spite of the simple word with its connotation of a simple definition, there does not seem to be a standard definition of what may be a much more complex concept).

The evidence to date (and it's not earth shaking) seems to bear mainly on meat (beef) and, possibly, fats.

Thus, it can be seen that the jury is far from in and that the basic questions have only been scratched.

One should also bear in mind that correlation does not necessarily imply causation. For a period of time there was a good correlation in Hamburg, Germany between the number of stork's nests and the number of babies born! It is also important to realize (with respect to other diseases and factors as well) that even if a causal relation can be reasonably demonstrated, that does not *necessarily* mean that modification of the factor will modify the prognosis in the relevant people.

BIBLIOGRAPHY

Bandaru, S., et al.: "Animal Models for the Study of Dietary Factors and Cancer of the Large Bowel," *Cancer Research* 35:3421-3426, 1975.

Berg, J., Howell, M. and Silverman, S.: "Dietary Hypotheses and Diet-Related Research in the Etiology of Colon Cancer," *Health Services Reports* 88:915-924, 1973.

Burkitt, D.: "Epidemiology and Etiology," *JAMA* 231: 517-518, 1975.

Burkitt, D.: "Epidemiology of Cancer of the Colon and Rectum," *Cancer* 28:3-13, 1971.

Burkitt, D. P.: "Large Bowel Cancer: An Epidemiologic Jigsaw Puzzle," *JNCI* 54:3-6, 1975.

Chomachai, C. et al.: "The Effect of Bile on Induction of Experimental Intestinal Tumors in Rats," *Dis. Colon Rectum* 17:310-312, 1974.

Correa, P.: "Comments on the Epidemiology of Large Bowel Cancer," *Cancer Research* 35:3395-3397, 1975.

"Diet, Intestinal Flora, and Colon Cancer," *Nutr. Rev.* 33:136-137, 1975.

Finegold, S., et al.: "Fecal Bacteriology of Colonic Polyp Patients and Control Patients," *Cancer Research* 35:3407-3417, 1975.

Gori, G.: "Summary of the Informal Discussion of Dietary Factors and Cancer of the Large Bowel," *Cancer Research* 35:3432-3436, 1975.

Haenszel, W. (ed.): "Report of the Working Group on Studies of Cancer and Related Diseases in Migrant Populations," *Int. J. Cancer* 4:364-371, 1969.

Haenszel, W., Berg, J., Segi, M., Kurshara, M. and Locke, F.: "Large-Bowel Cancer in Hawaiian Japanese,"*JNCI* 51: 1765-1779, 1973.

Haenszel, W. and Correa, P.: "Cancer of the Colon and Rectum and Adenomatous Polyps—A Review of Epidemiologic Findings," *Cancer* 28:14-24, 1971.

Haenszel, W. and Kurihara, M.: "Studies of Japanese Migrants. I. Mortality from Cancer and Other Diseases Among Japanese in the United States," *JNCI* 40:43-68, 1968.

Hill, M. J.: "Metabolic Epidemiology of Dietary Factors in Large Bowel Cancer," *Cancer Research* 35:3398-3402, 1975.

Hill, M.: "The Role of Colon Anaerobes in the Metabolism of Bile Acids and Steroids, and Its Relation to Colon Cancer," *Cancer* 36:2387-2400, 1975.

Irving, D. and Drasar, B.: "Fibre and Cancer of the Colon," *Br. J. Cancer* 28:462-463, 1973.

Kassira, E. et al.: "Colon Cancer: An Epidemiological Survey," *Am. J. Dig. Dis.* 21:205-214, 1976.

MacGregor, I.: "Carcinoma of the Colon and Stomach—A Review With Comment on Epidemiologic Associations," *JAMA* 227:911-915, 1974.

Modan, B. et al.: "Low-Fiber Intake as an Etiologic Factor in Cancer of the Colon," *JNCI* 55:15-18, 1975.

Moore, W. and Holdeman, L.: "Discussion of Current Bacteriological Investigations of the Relationships Between Intestinal Flora, Diet, and Colon Cancer," *Cancer Research* 35:3418-3420, 1975.

Narisawa, T.: "Effect of Vitamin A Deficiency on Rat Colon Carcinogenesis by MMNG," *Cancer Res.* 36:1379-1383, 1976.

Narisawa, T. et al.: "Promoting Effect of Bile Acids on Colon Carcinogenesis After Intrarectal Instillation of MMNG in Rats," *JNCI* 53:1093-1097, 1974.

Reddy, B. et al.: "Effect of Quality and Quantity of Dietary Fat and Dimethylhydrazine in Colon Carcinogenesis in Rats," *Proc. Soc. Exp. Biol. Med.* 151:237-239, 1976.

Reddy, B. et al.: "Effects of Dietary Fat Level and Dimethylhydrazine on Fecal Acid and Neutral Sterols Excretion and Colon Carcinogenesis in Rats," *JNCI* 52:507-511, 1974.

Reddy, B. et al.: "Effects of High Risk and Low Risk Diets for Colon Carcinogenesis on Fecal Microflora and Steroids in Man," *J. Nutr.* 105:878-884, 1975.

Reddy, B. et al.: "Further Leads in Metabolic Epidemiology of Large Bowel Cancer," *Cancer Research* 35:3403-3406, 1975.

Reddy, B. and Wynder, E.: "Large-Bowel Carcinogenesis: Fecal Constituents of Populations With Diverse Incidence Rates of Colon Cancer," *JNCI* 50:1437-1442, 1973.

Reddy, B. et al.: "Promoting Effect of Sodium Deoxycholate on Colon Adenocarcinomas in Germ-free Rats," *JNCI* 56:441-442, 1976.

Rogers, A. and Newberne, P.: "Dietary Effects on Chemical Carcinogenesis in Animal Models for Colon and Liver Tumors," *Cancer Research* 35:3427-3431, 1975.

"Roughage in the Diet," *MWN:* 35-42, Sept. 6, 1974.

Smith, R. D.: "Checking Out the Fiber Fad," *The Sciences* 16:25-29, 1976.

Wattenberg, L.: "Effects of Dietary Constituents on the Metabolism of Chemical Carcinogens," *Cancer Research* 35:3326-3331, 1975.

Wattenberg, L.: "Potential Inhibitors of Colon Carcinogenesis," *Am. J. Dig. Dis.* 19:947-953, 1974.

Wolff, I. and Wasserman, A.: "Nitrates, Nitrites, and Nitrosamines," *Science* 177:15-19, 1972.

Wynder, E. and Reddy, B.: "Dietary Fat and Colon Cancer," *JNCI* 54:7-10, 1975.

Wynder, E. and Shigematsu, T.: "Environmental Factors of Cancer of the Colon and Rectum," *Cancer* 20:1520-1561, 1967.

Wynder, E. et al.: Environmental Factors of Cancer of the Colon and Rectum II. Japanese Epidemiological Data," *Cancer* 23:1210-1220, 1969.

Wynder, E., So, B. and Reddy, B.: "Experimental Studies of Large Bowel Cancer—Human Leads to Experimental Application." Manuscript of a verbal presentation.

Wynder, E. and Reddy, B.: "Metabolic Epidemiology of Colorectal Cancer," *Cancer* 34:801-806, 1974.

Wynder, E. and Reddy, B.: "The Epidemiology of Cancer of the Large Bowel," *Am. J. Dig. Dis.* 19:937-946, 1974.

Wynder, E.: "The Epidemiology of Large Bowel Cancer," *Cancer Research* 35:3388-3394, 1975.



THE PERFECT GET-AWAY PLACE FOR YOU, YOUR FAMILY, YOUR COMPANY.

MOUNTAIN VIEW CONDOMINIUM VILLAS

Lake Arrowhead announces their brand new Mountain View Condominium Villas. These new Lake Arrowhead Condominiums are the most beautiful to be found anywhere—

- Rustic exterior design
- Central heat and airconditioning
- Fully equipped electric kitchen
- Washer/Dryer included
- Wood burning fireplace
- Wall to wall carpeting
- 2-1/2 baths
- Ample inside and outside storage
- Spacious sun deck
- Spectacular mountain view

Prices begin at $46,900

And here's more for you, after a nominal monthly maintenance charge and reasonable amenity fees!

- Membership in the Lake Arrowhead Country Club
- Championship 18 hole golf course
- Tennis and Swim Club
- 500 acre lake perfect for water sports and fishing
- Riding stables and mountain trails
- Picnic and recreational areas

For complete information and or personal inspection appointment call:

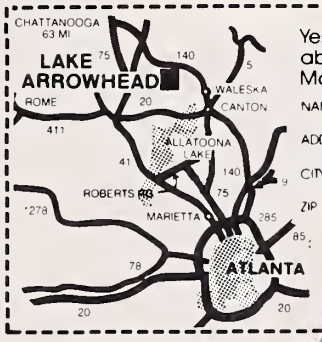
Lake Arrowhead Atlanta Office 266-1002

Or use this handy coupon.

Directions: From I-285 to U.S. 19 through Roswell to GA. 140. Once on GA. 140, follow the signs.

From I-75 go north to Roberts Road exit, then right to State Hwy. 5 to Canton, then north (left) on Hwy. 140 thru Waleska and follow the sign to Lake Arrowhead.

Lake Arrowhead is only 56 miles from Atlanta, 43 miles from Rome, 38 miles from Marietta, 21 miles from Cartersville, and 12 miles from Canton.



Yes, I am interested in learning more about Lake Arrowhead's brand new Mountain View Condominium Villas.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

Lake Arrowhead

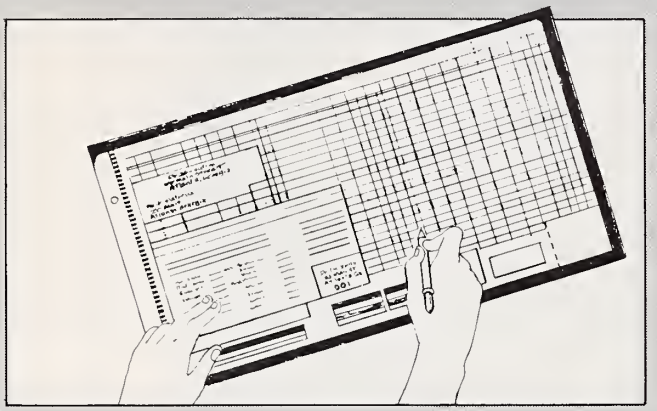
56 miles north of Atlanta...where a sound opportunity awaits you.

Another Diamondhead Corporation Community

THIS AD DOES NOT CONSTITUTE AN OFFER TO SELL IN ANY STATE WHERE SUCH AN OFFER IS PROHIBITED.

WHAT ACCOUNTING SYSTEM IS BEST FOR YOU?

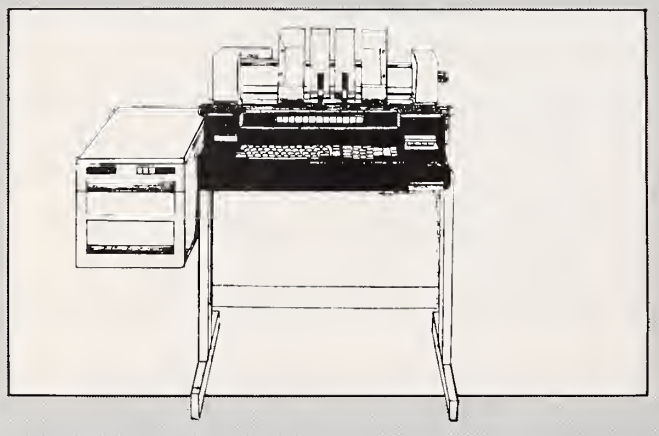
Accounting Systems Company, Inc., specialists in office efficiency systems for the medical office, wants to be your systems company.



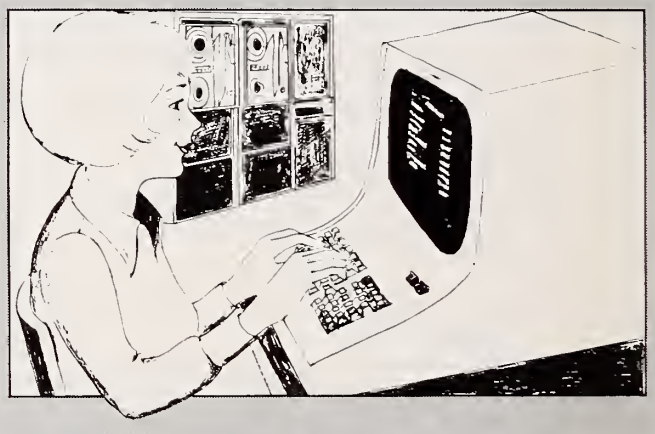
PEGBOARD: Due to its low initial cost and ease of operation, the pegboard or "one-write" system is used by more medical offices than any other system. Ideal for new and small practices.



OLIVETTI A-4: As your practice grows and your accounting needs become more time consuming and complex, the A-4 offers you greater accuracy and neatness with greater posting efficiency. We call the A-4 "The Automatic Pegboard".



OLIVETTI A-6: Small and medium size groups like the unique ability of our A-6 ledger oriented mini-computer. Here we have the best of both worlds; the ability to maintain an in-office ledger card and the advantages of a computer. Daily insurance preparation, month-end statements, and past-due analysis are but a few of the A-6's capabilities.



COMPUTER: Both service bureau and in-house capabilities. Our "on-line, real-time, part-time" service bureau approach to solving the problems in the medical office have been proclaimed "two years ahead of our competition" by our clients. Programs have been developed to meet the specific needs of your office.

Other products and services developed for the medical office are: Color-coded filing, alphabetical and numerical; Lateral, mobile and rotary shelving; Cross reference systems; Micro-film billing services; and Nation-wide collection services.

ASC has representatives through-out the southeast who are ready and able to help you with your system needs. It makes sense to deal with "The Specialists". Write or call today!

ACCOUNTING SYSTEMS COMPANY, INC.

P.O. BOX 216, FAYETTEVILLE, GEORGIA 30214, TEL: (404) 461-6083

JOURNAL
of the medical association of
georgia

Special Practice Management Section

Articles prepared especially for the Journal
by Professional Management Consultants

How to Select a Computer System 791
How to Manage Your Time 801
How to Have Better Collections 805

Doctor—Does this sound like your office?

Symptoms:

1. Office personnel bogged down in filling out a variety of insurance forms for private insurers, Medicaid and Medicare;
2. Delays in sending out up-to-date statements to patients;
3. Problems in maintaining and controlling accounts receivable records;
4. Complaints over headaches caused by excess paperwork;
5. Inconvenient and time-consuming filing systems.

Diagnosis:

paperwork nightmare

Treatment:

Relief of all these symptoms can be accomplished with one simple prescription. For a quick

Cure:

Call now for more information.

data med health systems

D M
H S

10510 Clara Dr., Roswell, Georgia 30075
(404) 992-5100

Would a Computer Help Your Practice?

Thinking of using electronic data processing in your practice? This article will help you know what to look for and how to avoid mistakes

MORE PHYSICIANS TODAY are showing interest in data processing than ever before. Most of this interest has been generated by a major problem which is plaguing medical service entities: PAPERWORK. Specifically, it manifests itself most clearly in the number of statements and insurance claim forms prepared and mailed by physicians each month. Some physicians' offices appear to have become annexes of insurance companies. Is yours?

Many physicians have seen their practice overhead rise dramatically as the paperwork load increases. They have had to employ additional personnel to try and stem the tide. Increasingly, these physicians are looking to data processing as a way of processing the paperwork, while yet allowing them to control their overhead.

Why the computer? Several things have happened in recent years in the field of data processing that have caught the eye of many physicians. First, the cost of computing power has been drastically reduced with the advent of smaller and less expensive (mini) computers. Second, while many physicians cannot afford to have an "on premises" computer, they now are able to utilize the services of "off premises" computers.

Some physicians who have turned to data processing have found relief in the paperwork jungle. Others have become embittered and disappointed over the entire data processing concept. *Data processing properly justified, planned, installed, and used can be an effective tool in helping manage the constantly increasing paperwork faced by physicians in private practice.*

The computer can take routine, large-volume jobs and process them in short time frames. Properly programmed and operated, it can compute, sort, and rearrange data into meaningful formats for use by physicians and their managers. The printed reports can be used by the physicians as they pursue their clinical activities. The computer also can be used by physicians to aid them in managing their practices. Contrary to the almost universal belief, data processing does not always reduce the clerical cost associated with the previous manual methods of processing data. But it almost always provides tighter controls and more timely information.

A word of warning. Successful data processing operations call for a high level of internal discipline and a strong commitment to organization. Without these, there is little hope of the operation reaching

* Prepared for the *Journal* by Practice Productivity Inc., a management consulting firm offering educational and motivational workshops on sound business concepts for physicians and their assistants. The address of Practice Productivity Inc. is 2000 Clearview Ave., Atlanta, Ga. 30340.

its potential. *Data processing cannot be approached in a casual manner.*

Before consideration can be given to any form of data processing, there are a number of basic points physicians and their business managers must discuss.

1. First, physicians must have their practice and professional goals clearly defined. These goals should be structured in terms of three- and five-year time frames. An example of one of these goals might be the number of physicians ultimately to be associated with the practice. Another, will the practice offer any unique services in the future? If these goals haven't been defined prior to considering data processing, the chances are good the data processing operation will not adequately service the practice.

"Contrary to the almost universal belief, data processing does not always reduce the clerical cost associated with the previous manual methods of processing data"

2. A feasibility study should be conducted to determine if there is actual justification for thinking about converting to data processing. The office manager and the clinic accountant should be the primary principals in this study. The physicians are also encouraged to participate, their time permitting. If no one in the practice has the necessary abilities, then an outside consultant should be secured. Many of the major accounting firms have personnel on board that specialize in data processing consulting. The firm that is used must have a broad background in data processing and be familiar with current hardware and software. Certainly, a background working in the medical services industry would be most helpful.

The feasibility study should concern itself with volumes of data presently being processed. As a general statement, if the practice is preparing and mailing less than 1,000 statements per month and the principal reason for using data processing is statement preparation, it does not appear the equipment or the service can be justified. The number of insurance claim forms prepared each month must be considered. The number, nature and format of the various financial reports must be considered. Clinical information storage and retrieval might be justified, if the physicians are into a great deal of research.

Certainly, the aims of the data processing operation need to be clearly defined. What is the operation to accomplish? Is it to aid in reducing clerical cost? Is it to process the paperwork of the practice on a timely basis? Is it to be used to tighten up control of information within the practice? Information and records requirements of the practice need to be determined. Finally, all of the present operations must be costed out to provide some basis of comparison against the proposed data processing operation.

3. If, after the feasibility study has been completed, there appears to be justification for considering data processing, a series of specifications should be drawn up for presentation to vendors of the equipment or services. The intent of this article is not to get into the details of specification preparation. Generally speaking, the specifications should include detail about the systems processing, equipment, initial costs, staff requirements, and services the vendors will perform. All of these specifications should be clearly spelled out. In most cases, it will be necessary for the physicians to retain the services of a data processing consultant or a member of a major accounting firm who specializes in this type of consulting. A time limit needs to be established for the various vendors to return their proposals to the physicians. Again, the consultants can assist in evaluating these proposals.

4. Essentially, there are three basic approaches to data processing that may be considered:

The first is "on premises" equipment. This is where you own or lease the equipment and it resides within the practice.

The second is the service center approach. This

GLOSSARY OF TERMS USED IN THIS ARTICLE

Hardware—the "nuts and bolts" of the computer, the actual physical parts of the machine, purchased from the manufacturer.

Software—programs (which may be composed by the user, by the manufacturer, by a service bureau or others), which direct the computer to perform specific tasks, i.e., billing, payroll, retrieval of research information, indexing, etc.

Time Sharing—a system whereby many users can virtually simultaneously use a computer in a different location.

Time-Sharing Terminal—the remote device through which the user accesses the computer. It usually takes the form of a typewriter-like unit through which the user inputs data and receives printed output.

is where a business such as a bank or manufacturing firm, etc., has its own computer, but doesn't utilize it full time. Time on the computer is sold to others wishing to buy it. Sometimes companies will develop the programs for those wishing to buy time on their equipment. In other instances, they purchase programs from others who have developed them, and sell a packaged service to their customers. Some of these firms cater to a given market, such as hospitals, physicians, dentists, etc. These firms may offer two approaches to their clients. The first may be one of having the client prepare all data for entry into the data processing operation and then transport it to the computer either by mail or some other form of transportation. The second approach might be one of placing some type of a data communication device in the client's office. This time-sharing terminal then becomes the vehicle for carrying the data to the data processing operation which is at some remote location.

The third approach is when the firm specializes in data processing services for medical clients only. They have programs specifically for use by physicians' offices. In some cases, they will modify these programs, so they will accommodate the present operations of the clients. As with the second approach, they usually use some type of data communications device, which provides the link between the practice and the data processing operation at some remote site.

In order to properly select the equipment or service that best serves the practice, it is recommended that a specialist in data processing be used.

5. Once proposals have been received from the various vendors, and evaluated, the physicians need to thoroughly check out some of the smaller vendors for stability. This is to ensure they will be around for a considerable period after the physicians have contracted for the equipment or service.

a. Secure financial statements from the vendors for the last three years of operations. Have the practice accountant carefully analyze them.

b. Secure the names of other practices presently using the equipment or service. Make certain these references are comparable in size and application to your operation.

c. Determine what support the vendors promise and then actually deliver to their clients. Do they have local systems support personnel? How long does a client have to wait to secure vendor assistance if they are having problems?

d. Determine if the programs are compatible with the present operations of the practice. Must the programs be modified? Who pays for the modification? Who owns the programs after they have been modified? Ownership can be very important if the

THE CONTRACT

Here are some of the things that should be in your data processing contract:

a. Does the contract contain the date the system will be "up and operational?"

b. Does the contract make provision for running the new system parallel to the old system for a number of months?

c. Are there provisions in the contract for the correction of errors caused by vendor's negligence?

d. Does the contract clearly spell out the pre- and post-conversion systems support the vendor is to provide?

e. Is the cost of the support in (d.) above associated with a part of the conversion effort?

f. Does the contract spell out what output (reports, tapes, etc.) the vendor is to provide?

g. Does the contract spell out who owns the program? Does it also spell out who pays for any modifications in the program?

h. Does the contract indicate how much notice shall be given if either one of the parties to the contract should decide to discontinue the use of the equipment or the service?

i. Are there provisions in the contract for reducing payments to the vendor if the equipment or the service is not operational for a substantial amount of time due to vendor problems?

j. Are there provisions in the contract for the vendor to provide alternate methods or processing if the main equipment or the service is not operational?

k. Does the contract discuss client recourse to the vendor if the output of the system is not usable due to vendor negligence or other vendor problems?

l. Does the contract provide for the type and format of the information the client will receive if the vendor should discontinue business? Are timing considerations mentioned?

m. Are all charges for services to be rendered or equipment to be leased or purchased clearly spelled out in the contract?

n. Does the contract require the vendor to supply a detailed statement to the practice each month?

o. Are inactive and active accounts defined in the contract?

p. Does the contract stipulate how much notice the vendor must give the practice before raising the price of the service?

NIXDORF COMPUTER

Over 50,000 Business Computers and Terminal Systems. All over the world.

INTRODUCING: M.C.A.P.

a *MEDICAL CLINIC APPLICATION PACKAGE*

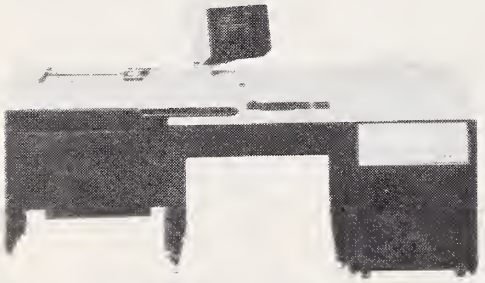
DESIGNED TO PERFORM AUTOMATIC CYCLE PATIENT BILLING, MEDICAID, MEDICARE, BLUE SHIELD, AND COMMERCIAL BILLING USING THE NEW UNIFORM CLAIM FORMS.



NIXDORF: does it all

RESPONSIBILITY TEAM OF EXPERTS.

A SYSTEMS EXPERT ANALYZES YOUR INFORMATION NEEDS: A PROGRAMMING SPECIALIST TAILORS M.C.A.P. TO MEET THOSE NEEDS: A CUSTOMER REPRESENTATIVE QUICKLY PUTS M.C.A.P. TO WORK BY TRAINING YOUR PERSONNEL. A FIELD ENGINEER REMAINS AVAILABLE TO INSURE YOUR M.C.A.P. ALWAYS RUNS SMOOTHLY AND DELIVERS FULL CAPACITY.



MODEL 8870: A COMPACT EASY TO OPERATE COMPUTER FOR CLINICS AND GROUPS WHICH AUTOMATES THE FOLLOWING FUNCTIONS:

- SERVICE ENTRY
- CASH RECEIPTS
- AGED TRIAL BALANCE
- PATIENT BILLING
- MEDICAID, MEDICARE, AND INSURANCE REPORTING
- SERVICE ANALYSIS
- REVENUE ANALYSIS
- PATIENT HISTORY

THE TOTAL SERVICE COMPANY: Nixdorf offers the total support approach to data processing, providing complete facilities from training and application software programming to total maintenance. Nixdorf personnel perform all marketing, systems analysis, programming, training, and maintenance functions. This concept of total support from one company assures you of a fully supported system guaranteed by Nixdorf's policy of single source responsibility.

SIMPLICITY OF OPERATION: The 8870 is an operator oriented system which utilizes video display terminals as the medium to give the operator step-by-step direction for program execution, and to provide visual verification of data entered into the system. The software allows for recovery from virtually any error condition, and contains simple correction procedures. The system is easy to install, and so simple to operate that any of your clerical personnel can learn to use the system with ease.

MODULARITY: The Nixdorf 8870 computer system is a field proven system which is powerful and versatile, offering impressive cost/performance characteristics in today's business computer market. The system continues to follow the Nixdorf concept of modularity, allowing great ease of expansion. You may start with a basic configuration of one disc drive, one matrix printer, and a CRT, and expand to as many as nine CRT's, multiple disc drives, and several printers of different types. As your data processing requirements increase due to company growth, the 8870 can be expanded and upgraded at the same time.

NIXDORF COMPUTER, INC.
Koger Executive Center
2945 Flowers Road South
Atlanta, Georgia 30341
(404) 455-1266

vendor goes out of business and the programs require subsequent modification.

e. Determine if the vendor is willing to run the new operation parallel with the old for several months at no cost to the practice.

f. Does the vendor provide a comprehensive training program for those who will be working with the equipment or service, and familiarization for those who won't be working with it? Are there operations manuals tailored to the operations of the practice? Are all computer runs fully documented?

g. Will the vendor assist in the pre-conversion systems work, and to what extent? Also, what post-conversion follow-up is provided by the vendor?

6. When all of the reviews and negotiations have gotten down to the contract stage, there are a number of things that need to be reflected in the contract. (For a partial list of items to include, see the box on 793.)

All contracts should be presented to the practice attorney for review. The review obviously needs to take place prior to signing the contract.

This article was designed only to highlight those areas to which medical practices and clinics should give a great deal of attention when considering data processing. As previously mentioned, most medical service entities do not have the level of sophistication to deal with the complexities of data processing. In those cases, they should look to outside consultants, or the management consulting arm of their CPA firm, if it is one of the larger firms in this country.

Many of the vendors of equipment and services provide seminars for potential clients. Where there is a high level of interest on the part of the physicians in data processing, the physicians should underwrite the cost of travel, meals and lodging and send a key person in the practice to one or more of these seminars to help educate them.

Properly used, computers can help physicians better manage their practices and can be helpful in research activities

Data processing, when properly implemented, can assist many physicians to reduce the crush of practice paperwork while still controlling their overhead. Investigate! A computer might be able to help your practice.

TEGA-SPAN CAPELLETS

FOR MORE ADVANCED NICOTINIC ACID THERAPY

Each capsule contains: . . . 400 mg of pure pelletized Nicotinic Acid

INDICATIONS: Tega-Span is indicated where reduction of serum cholesterol and total lipid levels in hypercholesteremia and hyperlipemia is desirable. It may also be useful in reducing xanthomatous tissue cholesterol deposits.

DOSAGE AND ADMINISTRATION: Usual dose is one or two capellets twice daily with or after meals. Since lower doses may control hyperlipidemia in some patients, the dosage should be individualized according to the effect on serum lipid levels. It is also to be noted that adverse reactions appear with great frequency early in therapy; in order to avoid these, it may be best to start the drug at low levels and increase dosage gradually.

Federal Law prohibits dispensing without a prescription

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTABLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

ANNOUNCING **Practice Productivity Inc.** WORKSHOP

BUSINESS ESSENTIALS FOR A MEDICAL OFFICE

one-day workshop for your medical office assistants

Co-Sponsored by the Medical Association of Georgia

This program has been approved for Continuing Education Units by the American Association of Medical Assistants, Inc.

9 AM to 5 PM

November 20, 1977	Atlanta	Peachtree Plaza
November 30, 1977	Columbus	Holiday Inn Airport
December 6, 1977	Augusta	Executive House
December 7, 1977	Savannah	Savannah Inn & Country Club
December 8, 1977	Macon	Macon Hilton
December 9, 1977	Atlanta	Peachtree Plaza

TOPICS: Telephone Management, Appointment Scheduling, Medical Records, Personnel, Billing Systems and Collection, Insurance Claim Processing.

Practice Productivity Inc. is a national management consulting firm located in Atlanta. Physician-clients are engaged in the private practice of medicine. Practice Productivity offers educational and motivational workshops in sound business concepts to physicians, medical office managers, and medical assistants. It also provides in-depth, on-premise consulting to physicians.

For further information, contact Duane M. Johnson, Ph.D., Executive Vice-President, Practice Productivity, Inc. Telephone 404/455-7344, or toll free Registration Desk 800/241-6228.

Registration Form

Please register the following persons (type or print)

Name Position Date Will Attend

1. _____
2. _____
3. _____
4. _____

From the office of:

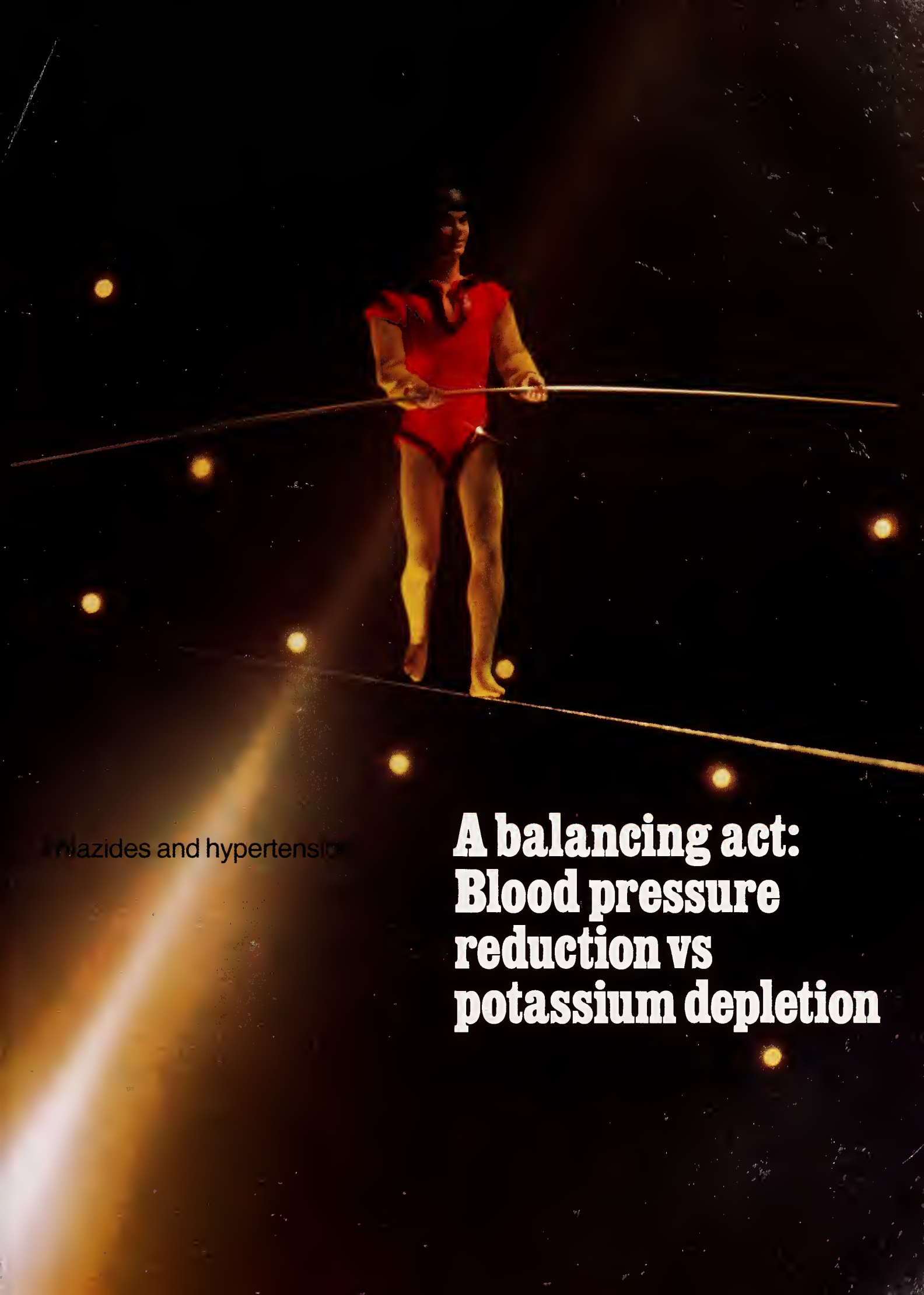
Name _____ Specialty _____ Telephone: ( ) _____

Address _____ City _____ State _____ Zip _____

Full tuition fee of $ _____ is enclosed at $75 per registrant. Tuition includes course materials and luncheon and MUST ACCOMPANY THIS FORM. (There is a $10 handling fee deducted on all refunds for cancellations received at least one week in advance of course; no refund thereafter.)

Make check payable and mail to:

PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30040



azides and hypertensio

A balancing act: Blood pressure reduction vs potassium depletion

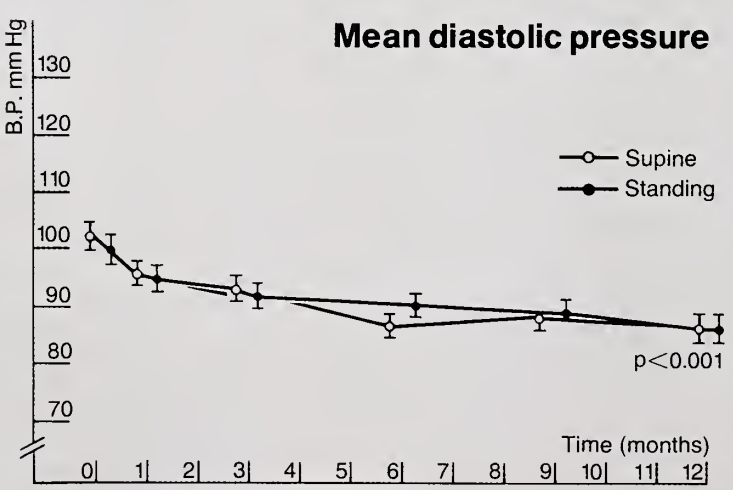
From a 1-year study of 18 patients with mild uncomplicated hypertension published in The Lancet*

Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

Diastolic blood pressure down 12-15%



"The mean pretreatment blood pressure was 170/103 mm Hg (supine) and 166/100 mm Hg (standing). Diastolic pressure continued to fall over the first 6 months and then there was no further change up to 1 year...The mean blood pressure at 12 months was 153/88 mm Hg (supine) and 142/88 mm Hg (standing)."

"The patients were receiving a single daily dose of 10 mg bendrofluazide [bendroflumethiazide]...there were no apparent side effects from the medication."

*Wilkinson PR et al: The Lancet 1:759-762, 1975.



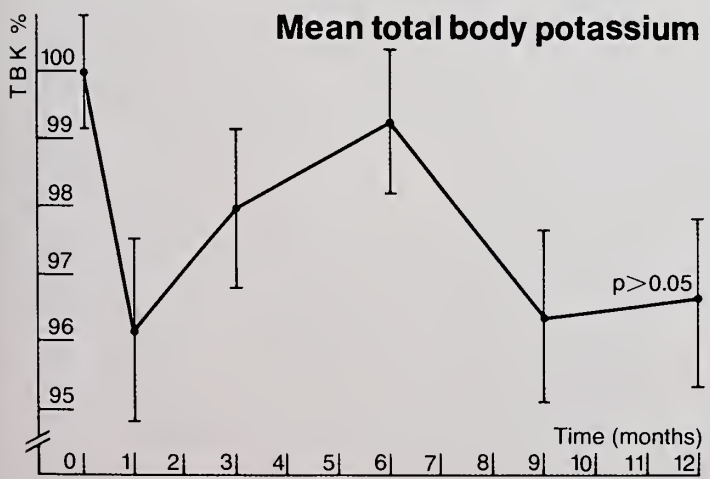
Once a day

Naturetin®

Bendro-
flumethiazide
Tablets N.F.

2.5, 5 and 10 mg

Potassium stabilized at 96% mean TBK



"The amount of potassium loss during the period of study did not seem to be clinically significant."

"A serum potassium of less than 3.5mmol per litre is often taken as the value below which potassium supplements should be given...At an arbitrary lower value for serum potassium of 3.0mmol per litre, few patients, our data suggest, would need potassium supplements. Our findings with TBK support this view..."

See next page for full prescribing information.

Once a day
Naturetin®
Bendroflumethiazide Tablets N.F.

NATURETIN®-2.5
NATURETIN®-5
NATURETIN®-10
Bendroflumethiazide Tablets N.F.

DESCRIPTION
Naturetin (Bendroflumethiazide Tablets N.F.) is a benzothiadiazine derivative containing a benzyl and a trifluoromethyl group. It is a potent oral diuretic and antihypertensive agent available as compressed tablets providing 2.5, 5.0, or 10 mg. bendroflumethiazide.

ACTIONS
The mechanism of action results in an interference with the renal tubular mechanism of electrolyte reabsorption. At maximal therapeutic dosage all thiazides are approximately equal in their diuretic potency. The mechanism whereby thiazides function in the control of hypertension is unknown.

INDICATIONS
Naturetin (Bendroflumethiazide Tablets N.F.) is indicated as adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis and corticosteroid and estrogen therapy.

Bendroflumethiazide has also been found useful in edema due to various forms of renal dysfunction such as: nephrotic syndrome, acute glomerulonephritis, and chronic renal failure.

Naturetin (Bendroflumethiazide Tablets N.F.) is indicated in the management of hypertension either as the sole therapeutic agent or to enhance the effectiveness of other antihypertensive drugs in the more severe forms of hypertension.

Usage in Pregnancy. The routine use of diuretics in an otherwise healthy woman is inappropriate and exposes mother and fetus to unnecessary hazard. Diuretics do not prevent development of toxemia of pregnancy, and there is no satisfactory evidence that they are useful in the treatment of developed toxemia.

Edema during pregnancy may arise from pathological causes or from the physiologic and mechanical consequences of pregnancy. Thiazides are indicated in pregnancy when edema is due to pathologic causes, just as they are in the absence of pregnancy (see WARNINGS). Dependent edema in pregnancy, resulting from restriction of venous return by the expanded uterus, is properly treated through elevation of the lower extremities and use of support hose; use of diuretics to lower intravascular volume in this case is illogical and unnecessary. There is hypervolemia during normal pregnancy which is harmful to neither the fetus nor the mother (in the absence of cardiovascular disease), but which is associated with edema, including generalized edema, in the majority of pregnant women. If this edema produces discomfort, increased recumbency will often provide relief. In rare instances, this edema may cause extreme discomfort which is not relieved by rest. In these cases, a short course of diuretics may provide relief and may be appropriate.

CONTRAINDICATIONS
Bendroflumethiazide is contraindicated in anuria.

It is also contraindicated in patients who have previously demonstrated hypersensitivity to it or other sulfonamide-derived drugs.

WARNINGS
Bendroflumethiazide should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may be additive or may potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Usage in Pregnancy. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers. Thiazides appear in breast milk. If use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS
Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are: dryness of the mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity.

Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes mellitus may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If emergency surgery is indicated, preanesthetic and anesthetic agents should be administered in reduced dosage.

If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

ADVERSE REACTIONS
Gastrointestinal System: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), and pancreatitis. *Central Nervous System:* dizziness, vertigo, paresthesia, headache, and xanthopsia. *Hematologic:* leukopenia, agranulocytosis, thrombocytopenia, and aplastic anemia. *Dermatologic-Hypersensitivity:* purpura, photosensitivity, rash, urticaria, and necrotizing angiitis (vasculitis, cutaneous vasculitis). *Cardiovascular:* orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. *Other:* hyperglycemia, glycosuria, occasional metabolic acidosis in diabetic patients, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, and restlessness.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION
Therapy should be individualized according to patient response. This therapy should be titrated to gain maximal therapeutic response as well as the minimal dose possible to maintain that therapeutic response.

Diuretic: The usual dose is 5 mg. once daily, preferably given in the morning. To initiate therapy, doses up to 20 mg. may be given once daily or divided into two doses. A single daily dose of 2.5 to 5 mg. should suffice for maintenance.

Alternatively, intermittent therapy may be advantageous in many patients. By administering the preparation every other day or on a three to five day per week schedule, electrolyte imbalance is less likely to occur; however, the possibility still exists.

In general, the lowest dosage that achieves the therapeutic response should be employed.

Antihypertensive: The suggested initial dosage is 5 to 20 mg. daily. Maintenance dosage may range from 2.5 to 15 mg. per day, depending on the individual response of the patient. When the diuretic is used with other antihypertensive agents, lower maintenance doses for each drug are usually sufficient.

STORAGE
Store at room temperature; avoid excessive heat.

HOW SUPPLIED
2.5 mg. tablets in bottles of 100, 5 mg. tablets (scored) in bottles of 100 and 1000, and 10 mg. tablets (scored) in bottles of 100.

SQUIBB®

©1977 E.R. Squibb & Sons, Inc. 477-501

Managing Your Time Through Effective Office Practice Scheduling

LEIF C. BECK, C.P.B.C., LL.B. *and* VASTILIOS J. KALOGREDIS, J.D.,
Bala Cynwyd, Pennsylvania*

SCHEDULING OFFICE HOURS is a direct application of work to time. The appointment book creates patterns for handling each office hour (and even each ten- or fifteen-minute slot within the hour) in much the same way as someone's budget serves to pattern his spending. Why, then, are most doctor's office schedules created with so little critical evaluation?

Perhaps the reason is simply that neither the physician nor his/her office manager has recognized that there really are some choices to be made. An office schedule can and should be molded to best serve the practice, and experimentation with the possible variables should continue until that "best" approach has been found.

Failure to create decent office schedule formats can result in a series of complaints proving that time management is important. Some of the difficulties include: (a) an inability to finish office hours even reasonably within the scheduled time; (b) a constant overcrowding of the waiting room, with patient gripes as to long delays; (c) disruptions caused by numerous emergency appointments and/or "walk-ins"; and (d) a continuing feeling that office hours are so hectic as to be unpleasant for doctor, staff and perhaps patient alike. These problems are more often than not curable if some conscientious attention and planning are applied.

Almost any practice having the described problems can indeed improve its office situation. To do so it must first recognize that there are some basic principles available for self-help. Some of those principles are discussed in this article. While all of them need not apply to every office, each must be critically evaluated for its possible application to a specific office.

1. *The Doctor Himself.* The primary problem of many offices running constantly behind schedule is the doctor himself. We too often receive aides' complaints that the doctor rarely arrives in time to start office hours as scheduled. A busy office starting its schedule thirty to sixty minutes late may, of course, stay that far behind (or more) throughout the day. The result frustrates the aides and is unfair to the patients.

"An office schedule should be tailored to fit the practice—not vice versa"

There are many legitimate reasons for a doctor's delay in beginning office hours. For surgeons, complications and/or delays in the operating rooms must certainly be accepted. Hospital rounds for any doctor may become longer than planned on some occasions. *But all too often the delays are for less than these legitimate reasons.*

In many cases, occasional justified delays lead to a *habit* of delays, whether justified or not. Thus a doctor whose office schedule begins at 10:00 may, for instance, begin to accept the "norm" of arriving at 10:30—even if he simply stops for a cup of coffee in the hospital lounge or visits longer than usual with other doctors or patients. Such a doctor should be sternly reminded that except for really legitimate reasons, his failure to start office hours on time is a symptom of bad medical practice time management.

Doctors should take their office obligations seriously enough that not all hospital duties are overriding. For instance, if surgery or rounds are extending longer than anticipated, some patient rounds might be deferred to later in the day (where medically insignificant). Similarly, new hospital consults can often be handled as well after mid-day office hours as ten minutes before the first office visit is scheduled. In short, the office schedule must be respected except where there is a *true* hospital priority.

2. *Scheduling to the Doctor.* If the doctor routinely enters the office after hours begin, serious consideration should be given to beginning his office schedule that much later. Some doctors' hospital practices have grown to the point that more time is needed to finish rounds, yet their schedules have never been adapted to that fact. In such cases, we submit the following principle: *An office schedule should be tailored to fit the practice and not vice versa.*

* Principal consultants of Management Consulting for Professionals, Inc., 403 GSB Barclay Building, Bala Cynwyd, Pa. 19004. Mr. Beck is the author of a book titled "The Physician's Office." This article was copyrighted by the authors, September 1977.

There is nothing inviolate about an office schedule. If a doctor cannot usually start until, say, 10:30, the printed sheet should not commit him to an earlier time. Efficiency calls for a periodic look at the physician's activities with the question whether his appointment book responds to his actual time use. This calls for open and constant communication between the doctor and staff.

3. *First Appointment.* Many offices are of necessity behind schedule from the very first visit. This results in a pressure to "catch up" from that time on. If, for example, the first patient is scheduled at 10:00, he or she will probably not actually be seen until 10:15 or later. A patient's arriving just 10 minutes late would contribute to this problem, as would the need for perhaps another 10 minutes in preparing a patient (undressing, taking blood, weighing, etc.) before seeing the doctor.

We recommend that practices start their office schedules ten or fifteen minutes *earlier* than the doctor really plans to see his first patient. In the above example, scheduling one or two patients at 9:45 should permit a doctor arriving promptly at 10:00 (or earlier to do some paper work) to start his hours with no delay. This is simply an application of our rule—"fit the schedule to the facts and not vice versa."

4. *Wave Scheduling.* All office visits are not the same, nor are all patients equally prompt. Nevertheless, most schedules are printed up in inflexible, equal time slots as though there were no variations. "Wave scheduling" is an attempt to streamline office schedules to conform to these differences.

There are many applications of the wave theory. Under the basic approach, a practice scheduling patients every 10 minutes might instead schedule three patients every half hour and none in between. If one of those patients is 15 minutes late, the odds are the other two would have kept the schedule intact. If one visit requires longer than normal time, the other two might be "quickies" to average out the time usage. The assumption is that the 10-minute patient average usually works out over several patients and that no patient should encounter more than a 20-minute delay.

Even if an office rejects this wave approach (as too many do without careful thought), a *modified* wave scheduling approach can be extremely helpful. For example, a primary care practice seeing one patient each 10 minutes might schedule two patients at 10:00, no one at 10:10, one patient at 10:20 and then repeat this half-hour cycle throughout the day. An Ob/Gyn practice might group prenatal check-ups into certain time slots for "wave" efficiency. Other wave approaches have become the base for working patients in needing unscheduled attention. The "double booking" of the work-ins can be allocated to specified slots at the beginning of different "waves," expecting each entire wave to work out within its overall time period.

5. *Grouping Procedures for Efficiency.* Another approach to greater time saving is to critically analyze how a practice can group various types of office visits together for more efficiency. The answer to this problem will vary from doctor to doctor. We are in no position to say how each physician should decide. What does strike us, however, is that so few doctors even ask themselves whether they can streamline their work this way.

Some Ob/Gyn men find they can more rapidly *and more effectively* handle all their routine OB check-ups if they are grouped in successive time slots. This would follow the well-recognized principle that greater mental efficiency arises when similar tasks are grouped together, so the mind need not jump across differing problems. If such is the case for a particular practice, it should be made known to the receptionist. She might, for instance, be instructed to schedule all such check-ups between 10:00 and 12:00 on certain days.

Other doctors find greater efficiency by a specific mix of long and short visits, or of new and old patients. Internists may prefer complete physicals to be scheduled at certain parts of each day. Whatever the preference, we urge each doctor to critically question it for himself and then to specifically instruct his receptionist as to the desired scheduling format.

We also suggest in many cases that a doctor deliberately experiment with different grouping approaches to assure he is following the most efficient routine for himself. Deliberate attention to the possibilities may open up new time-saving ideas for his, his office's and his patients' benefit.

"The doctor simply must take the time to teach his receptionist how his hours should be structured"

6. *Scheduling Open Times.* One of the prime reasons an office fails to close on time is the onslaught of late-scheduled patients—both emergencies and "walk-ins." These patients are too often tacked on to the end of an already crowded schedule, thus almost assuring a longer day. When such situations are routine, the scheduling system should recognize the facts and leave *open times* for them.

Probably the best time to leave open for these patients is the next to last hour before closing. If, for example, patients are scheduled until 5:00, we

would suggest leaving the hour from 3:00 to 4:00 open until the morning of that day. Even if more than the usual hour's patients are squeezed into that hour, there will hopefully be some chance to catch up with just a normal load during the last hour. The principle here would be to schedule the emergencies and walk-ins so there will be some chance to catch up before the end of the day.

We have also seen referral practices face an extremely serious problem. Their regular office schedules were filled so far into the future that newly referred patients could not be seen for weeks. These new patients, and their referring physicians, were the life blood of practice, and the delays often caused the loss of potential future income. The situation is particularly apt for surgical practices in which the potential patient may seek another doctor for his or her surgery rather than wait.

We have suggested to such surgical practices that they set aside certain "new patient hours" in their appointment books. These would be time slots of perhaps one hour or more which may be filled in *only* with new patients until a very few days before the day in question. The receptionist might, for example, be instructed that the new patient hours cannot be used for any other purposes until the last two days. During those last two days she should call other patients who may be willing to fill up those previously reserved time slots. New patients could thus be accommodated within only a few days, while there should be no lost time and income if new patients have not been scheduled.

7. *Training the Receptionist.* It should be obvious that the usefulness of so many of these special scheduling devices depends on the receptionist. This, in turn, is dependent upon the doctor's diligence in recruiting, training and regularly supervising that person. As with so much of practice, success depends on personnel—but personnel proficiency in turn depends upon the doctor's attention to it.

The doctor simply must take the time to teach his receptionist how his hours should be structured. If the schedule is disrupted, he should constructively discuss how corrections can be made. He should encourage the receptionist's own input, since she may best see the problems and the possibilities since she works with them every day.

Likewise, the doctor must train his aide to recognize what is truly an "emergency" requiring a prompt visit and what can be deferred for a routine later visit. She must take no chances in uncertain situations, but she also must learn to be extremely critical of patient requests. A doctor's receptionist can hardly handle this responsibility well without careful guidance from the physician. Spending time to communicate with staff on such matters is an investment that will reap tremendous rewards.

8. *Color Coding of Appointment Book.* One invaluable aid for receptionists is the use of color shadings on various time slots to guide scheduling priorities. The colors are so useful since the press of phone calls and patients may too easily cause a busy receptionist to forget the scheduling rules without a visual aid. Furthermore, since others in the office may substitute at the receptionist's desk in case of illness, lunch breaks, and the like (our studies have established that the primary receptionist will be at her station no more than 70% of the time), the visual aid may be of tremendous help to this lesser trained person.

Setting aside a certain time frame "for new patients only" prevents loss of future revenues

For example, one doctor's appointment book might have the hours from 10:00 to 12:00 shaded light red to indicate they are only for OB check-ups. The hour from 1:00 to 2:00 might be shaded in light blue to indicate reservation for new patients, and so on. Regardless of the scheduling format, the color coding can make its actual application by the receptionist much more likely.

9. *Office Staff Meetings.* The various scheduling ideas can best be applied to any office if all assistants are involved in their development. After all, they have the same stake in the use of office time as the doctor(s). They hear the patient gripes and they desire to get home on time also.

We urge good practices to hold regular office staff meetings at which scheduling principles can be discussed by all concerned. In fact, we can hardly imagine a busy practice's office staff meeting not including some discussion of scheduling problems, as they affect everyone's effective use of their time and energy. The free and honest input from assistants, including periodic discussion of possible changes, should help make the schedule book responsive to the practice—and not vice versa. The schedule is a living thing. It should change as the practice does.

10. *Summary.* No one or two of the ideas suggested in this article are certain of solving any particular office's patient flow problems. However, there are many possible ways to improve the situation. They simply require the physician's open-minded attention and the staff's cooperation. As stated, his efforts should be directed at tailoring the schedule to fit the practice, and not vice versa. If that truism is always kept in mind, the doctor and staff might find their office time being better spent.



CREDITORS MERCANTILE, INC.

Doctors & Hospitals Service Bureau

COLLECTION ACCOUNT CONTROL SYSTEM

Our Professional Collection System Insures:

- Easy Placement of Delinquent Accounts
- Prompt, Regular Follow-up
- Professional Telephone Contacts
- Approved Notices and Letters
- Bonded and Insured Protection
- High Recovery Ratios
- Maintenance of Customer Goodwill

We understand your credit and collection problems.

Established 1914

Charter Member American Collections Association
Member Associated Credit Bureaus, Inc.



4 Executive Park Dr., NE, P.O. Box 95806, Atlanta, Ga. 30347 (404) 321-0999

Professional management consultants give advice on how to establish a strong foundation for your Accounts Receivables

Your Office Can Have Good Collections!

PRESENTLY, MANY OFFICES don't. The inadequacies of the physical facility, the wrong person in the right place at the wrong time, or a less-than-forthright attitude with the patient cause many practices to dramatically expand the costs of running a medical office.

Interestingly enough, most of your patients *really expect to pay you.* The patient initiates an implied contract when he calls on you for professional service. Surely he expects the best from you—your full attention, proper diagnosis and treatment, and recovery from his affliction. He expects you to be surrounded by competent, trained and caring people to assist in his care. He expects you to be aware of him as a person and respect his waiting time. He also expects you to be surrounded by the proper equipment, laboratory, X-ray, and other services when needed.

And, again, he expects to pay you. What seems to go wrong? Why do so many practices have great difficulty obtaining payment for professional services?

Usually, it is a problem with:

a. the facility;
b. the people, or
c. communications.

Simply stated: Often the patient is not given the proper opportunity to pay. Let's do a quick survey of your practice.

Your Facility

Does it allow for financial discussions while maintaining the dignity of the patient? It does if you have provided for a private place, away from other waiting patients, for these discussions to take place. Logically, some very delicate conversations concerning the patient's illness or treatment will take place here, as well as counseling sessions on overdue accounts. The patient whose privacy is continually invaded will soon react by bolting for the door.

Any modification you can make in your facility to provide this privacy will help. A dutch-door, cutting a window near the exit area, or even a temporary room divider can be a great improvement.

Your People

The entire medical community is under pressure to contain costs. Many people feel that a national health program is imminent. Some people even feel that all medical care should be "free." The private practice of medicine, however, still requires payment of fees for professional services rendered, if it is to continue to provide these quality services. Most patients understand this. In fact, in some practices, the patient understands the needs of the system better than those who work within it.

Direct and honest communication with the patient at every opportunity is important. It is unfair to the patient to "shock" him with an unexpected large fee after the fact. It will likely go unpaid and will also cause bad feelings.

Your staff should discuss financial matters clearly and simply with the patient. You should support them in that role. Even when the patient backs away and says, "My insurance company will take care of all that," it will be important that your representative properly explain the role of the physician, the patient, and the patient's carrier. If this is not done, almost any breakdown between the patient and his carrier will be blamed on you.

It is essential, therefore, that your hiring and training techniques screen out personnel who cannot handle this phase of patient communications. Fate will guarantee a poor collection ratio to those practices who appoint a collection clerk who simply is unable to talk about money.

Absurd, you say! "Everyone can talk about money!" Not so. In recent surveys that we have taken among medical assistants, more than one-

* Prepared for the *Journal* by Practice Productivity Inc., a management consulting firm offering educational and motivational workshops on sound business concepts for physicians and their assistants. The address of Practice Productivity Inc. is 2000 Clearview Ave., Atlanta, Ga. 30340.

Leave the "PATIENCE" to us!



It's great to have a lot of patients . . . especially the paying kind. But leave the patience with the non-paying ones to us.

Relieve yourself of the aggravation and unpleasantness involved in personally soliciting payment on past-due accounts. Don't let time make the condition worse. You can place delinquent accounts of your patients in our hands for immediate proper treatment.

Prognosis: Complete recovery anticipated.

And what's more—we don't lose patients!

Credit Rating Bureau, Inc.
901-904 Carnegie Building
Atlanta, Georgia 30303
(404) 525-8477

"It pays to deal with a bonded collection agency"

third admitted to being "somewhat more than uncomfortable" talking to patients about money. Please don't select from that side of your staff for this important role. Obviously, more than half responded as being "comfortable" talking to patients about fees. But, how do you find out about their feelings on this important subject? Simply ask them! Most people are willing to give you a straight answer.

In a recent West Coast consulting experience, the receptionist/collection clerk actually harbored a deep resentment toward physicians in general. In her brief tour of employment, collections dropped 30%. No one was paying attention and it wasn't until some practice checks were returned by the bank marked "ISF" that anyone bothered to find out that there was indeed a problem. She later admitted that she thought all people were entitled to free medical care, that physicians made "too much" money, and felt she should play an active role in "helping" people. Why hadn't someone probed attitudes in the employment interview? Because there wasn't one; everyone was *too busy!*

Take time to select. Take time to train. *Your staff represents you!* The thoughts they express reflect on you. Have a collection philosophy, as well as a consistent policy. Have it in writing. Have them read it, acknowledge it, and implement it. Most importantly, you (or hopefully your Office Manager) must monitor and oversee the entire process.

Communications

Straightforward communications with the patient is the backbone of good collections. Patients facing major surgical procedures or extensive (and expensive) workups, as well as patients visiting the office for routine visits, should be made aware of potential charges, when that is possible. It is unusual for any course of treatment to be so unpredictable that some guidelines cannot be established. Patients can easily understand that unpredictable charges can occur in any treatment program, including surgery, as conditions change.

The physician must take time to select and train his/her staff. After all, the staff represents the physician

For patients incurring high charges for procedures, it is proper and fitting that your office provide supportive services to accommodate billing, collection and/or third-party reimbursement. The normal processes of sending statements, completing insurance claim forms, and providing other documentation are justifiable from a business view.

It is, however, a completely different situation economically to provide sophisticated clerical support for those typically office-incurred charges making up the majority of financial entries in your practice.

A casual look at the relative costs can be astounding, particularly in those practices exhibiting a high percentage of charges in the $8.00 to $25.00 bracket. In most practices (including surgically oriented practices), most entries into the financial system are for less than $25.00.

"The patient whose privacy is continually invaded will soon react by bolting for the door"

Let's look at the numbers.

In many efficient, simple bookkeeping systems, it is possible to generate a statement for as little as 50¢; those which are inefficient may readily escalate that cost to anywhere between $1.00 and $2.00. With 13¢ postage, 10¢ or 15¢ in forms, and with the most substantial cost, that of personnel time, to enter, gather, collate and copy information into the system, it isn't surprising that this soon becomes one of the most costly procedures continually carried on in the office.

In addition, collection experience indicates that the average account will require three to four mailings to accomplish a paid-up status. Even if your average mailing frequency is four, and you have a most efficient system (at 50¢ per statement), still your cost to collect that bill will be approximately $2.00. If your frequency is four and your "inefficient" system is cause for a cost factor of $2.00 per statement, your costs to collect may average nearly $8.00.

Remember, that cost is merely to collect the fee. Only the remaining amount is available to apply to general overhead factors such as salaries, rent, etc.

Consider, then, the net value of a $10.00 charge for a routine re-visit. If the patient does not pay at the office on the day of service, you must then spend from $2.00 to $8.00 to collect that fee.

When a $10.00 professional fee generates only $2.00 to $8.00 of actual income, costs are often not met. The historical result has been an increase in fees to the ultimate consumer—the patient.

Realistic pressures are coming that demand us to be more efficient. The consumer recognizes the scope of the problem and is individually and collectively seeking ways to contain the spiral.

By using good communication techniques, you can effectively enlist the patient's cooperation in attacking the problem. It is realistic to ask the patient to be prepared to pay for office visits amounting to

$25.00 or less at the time the service is rendered, by promulgating a *mutually beneficial* theme, such as:

> *"We are trying very hard to contain the costs of medical care and avoid fee increases as much as possible. Because the cost of billing has become so very expensive, we are asking your cooperation in keeping costs down by coming to the office prepared to pay for office procedures amounting to $25.00 or less. We thank you for your cooperation."*

This theme should be repeated as often as possible, but the best communication techniques involve:

1. Advising the new patient on the phone prior to his first visit.
2. Presenting a Patient Information Brochure explaining this policy in detail, as well as other pertinent practice policies.
3. Repeating the theme as part of a properly designed "Patient Registration Form" (an essential document for good collection techniques).
4. Reinforcing of the theme by both physician and staff as appropriate.
5. Further reinforcement throughout the billing sequence.

Establishing this collection policy is relatively easy. It is culminated at the collection desk by the collection person who merely presents the patient with a summary of charges incurred, gives details of the individual charges as needed, and awaits payment. The majority of patients quickly adapt and many will actually prefer your new system.

Dramatic results in cash flow and cost containment are obvious. Practices throughout the country, both urban and rural, are embracing the concept. The real and positive benefits to the patient in *actually* containing office overhead are dramatic, and the patient can understand that message.

In summary, we must spend more time and effort up front where real impact can be made on collections. In too many offices the effort is focused on delinquent accounts. There is still no good method for collecting them and, although one technique will work better than another, the tragedy is that we are dealing with relationships that have broken down. You, the doctor, become angry, the patient is already angry, your personnel are frustrated, and the once sacred doctor-patient relationship is destroyed. At that point, the patient becomes a messenger of poor public relations.

Remember, *most* of your patients expect to pay you when they request service. Don't put artificial roadblocks in that path.

TODAY'S HIGH COST OF DOING NOTHING

About a Personal Financial Plan

The TRA '76 — that's the Tax Reform Act of 1976, became effective January 1, 1977 and is being phased in over the next five years. It affects wills, trusts, investments and other financial transactions. Each of these needs to be reviewed in the light of the TRA '76. Its impact on your personal financial situation may require professional evaluation.

CONSOLIDATED PLANNING CORPORATION
Registered Investment Advisors
148 International Blvd., Suite 801
Atlanta, Georgia 30303
Telephone (404) 659-2920

For Practice Management Information Systems...

Call The Specialists Call Systemedics

- FOR improved cash flow and financial control
- FOR automatic processing of patient statements and insurance information
- FOR improved patient management through use of our Problem Oriented Record
- FOR continuing service and management assistance

Serving medical practices exclusively

Systemedics of Georgia
P.O. Box 28055
Atlanta, Ga. 30328
(404) 252-3835

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

250
90

When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort, and (3) compliance.

Zaroxolyn offers all three.

Effectiveness: In several long-term studies[1,2,3] Zaroxolyn brought moderately elevated blood pressure (average 167/113 mm Hg) down to the range of normotension—and held it there for up to four years.

Comfort-in-use: One investigator noted, "Patient cooperation was surprisingly good for a study of such duration. The once-daily schedule with metolazone (Zaroxolyn) no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate.[3]

Long-acting

Zaroxolyn®

(metolazone) Pennwalt

2½ mg, 5 mg and 10 mg tablets

once-daily antihypertensive diuretic

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:

1. Dornfeld L, Kane R: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Curr Ther Res* **18**:527-533, 1975.
2. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Curr Ther Res* **20**:745-750, 1976.
3. Data on file: Medical Department, Pennwalt Prescription Products.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester New York 14603

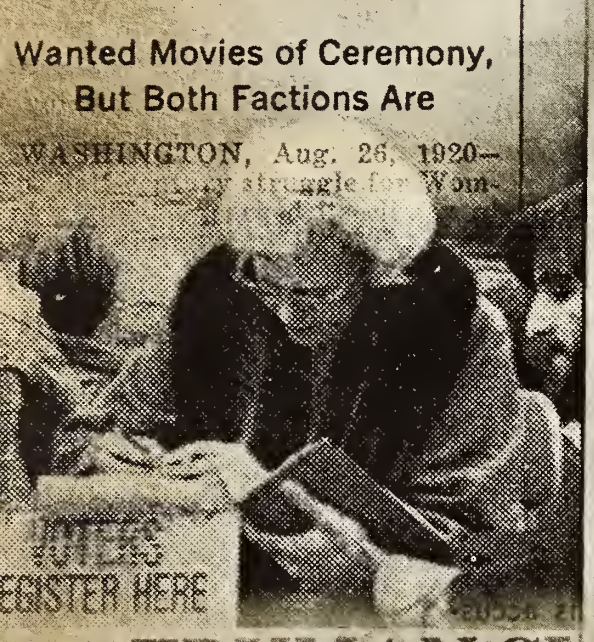
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws—He C the Measure 'Cornerstone' of His Economic Progran

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congr s.

Mr. Roosevelt cal the m "the cornerstone which is eing t is mea s c ple

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

JUL SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

The South's Most Complete BMW Dealer



CHRIS MOTORS

Whatever your BMW needs are, we can take care of them. We can sell you a BMW, or offer you a lease that includes a FREE LOAN CAR. We can take care of routine service, or handle any major repairs. We have our own body shop especially for BMW's. And we carry an excellent supply of BMW parts and accessories.

That's why Chris Motors is the South's most complete BMW dealer. Let us be yours.

1606 CHURCH STREET, DECATUR, GA.

PHONE (404) 292-1400 **NEAR NORTH DEKALB MALL**

editorials
editorials
editorials

MAG Committee Helps Improve Jail Conditions

GEORGIA, THROUGH THE EFFORTS of the MAG, was chosen by the AMA in early 1976 as one of six pilot states for the purpose of developing and implementing plans to improve health care in jails. Most of us are aware of the deplorable health conditions that exist in many of our jails, and this seemed like a good opportunity to ameliorate that situation in our own state.

Several goals for the project were outlined originally, and others have evolved since. As of now, the main goals include:

1. The development of national standards for acceptable health care in jails;
2. The assisting, by the medical profession, of jails to meet these standards;
3. The accreditation, by the MAG and the AMA, of those jails who meet the standards;
4. The development and offering of educational and training modules related to health care for jail personnel;
5. The involvement of organized medicine, particularly at the County Society level, in assuring quality health care in our jails.

The MAG began by establishing a committee to forward these goals. The committee sees its role as twofold: one, to act as a review body, to send to the AMA recommendations regarding the accreditation of specific jails; two, to implement the other activities implied in the stated goals.

National standards have been developed in draft form, and presently are in the process of being refined and condensed. MAG has had input into these decisions. It is anticipated that the final form of these standards will be published before the end of this year.

MAG has been active in assisting five pilot jails around the state in meeting minimal standards of health care for their inmates. We hope to be working with several additional jails in 1978, and we expect that the movement will spread as information and interest grows.

DeKalb County Jail already has been accredited, through our efforts, and we anticipate one or two more jails to be successful within the next couple of months.

By the time this issue of *JMAG* reaches you, we will have given a workshop developed by your committee to a couple of dozen jailers on receiving-screen-

ing of inmates. This course will teach booking officers in jails some rudiments of evaluation of health problems and the proper handling and referral of these problems. In addition, we will be teaching some skills of the screening process, history taking, and recognition of the presence of physical and emotional problems, including drug dependence, and what to do about them. We will touch on legal implications, confidentiality, and the availability of resources in the community. A manual covering the entire course will be distributed to all participants, and another manual on how to offer such workshops in the future also will be developed. It is hoped similar workshops will be conducted throughout the state over the next year or two.

Additional workshops are being planned now to address such issues as: handling emotionally disturbed inmates; administration of medications; nutrition; recognition of common physical and emotional problems peculiar to inmates of correctional institutions; emergency and first aid procedures necessary for use by correctional officers.

A workshop is planned for February or March, 1978, for physicians who are or would like to become involved in health care in jails. A speaker's kit and knowledgeable speakers will be available for County Medical Society meetings, or other interested groups. It is hoped through this mechanism that we will sensitize communities to the problem, and will activate them, at the local level, in becoming involved in improving the health care of a frequently neglected segment of our society.

This is one more aspect of the work of your Medical Association in helping to solve problems. It, along with many other activities of the MAG, shows evidence of our concern, our leadership, and our expertise. May it ever be thus!

John Rhodes Haverty, M.D.
Chairman
MAG Committee on Prison Health Care

Will We Ever Learn?

THE ADVERTISING INDUSTRY has demonstrated, beyond any doubt, the importance of each and every word in the art of persuasion. Nonetheless, the medical profession and insurance carriers choose the most derogatory phrase possible to characterize professional liability. Compare the impact of the word *MALPRACTICE* with the words utilized by the banking industry. A bank proudly announces that all deposits are protected by the Federal Deposit Insurance Corporation. They wisely avoid reference to such odious terms as embezzlement or bank failure. Employees of the bank are "bonded." The word theft is carefully obscured. "Insurance," "deposit," "federal" and "bonded" are words that evoke images of protection and solidarity. Each of you may call to mind the euphemisms employed by other commercial enterprises when referring to liability for a service or product.

As members of an ancient and honorable profession, we are proudly responsible for our activities. Professional responsibility is an attribute which we cultivate. The word m---------e should be banished from our vocabulary. Leave this obscenity to the attorney for the plaintiff. Physicians should discuss only professional responsibility.

Jack A. Raines, M.D.
Vice Chairman
MAG Board of Directors

TOUCH THE MERCHANDISE



At MacTavish Office Furniture, we don't think it's fair to have a customer order from a catalog. We think you should be able to touch the wood, sit in the chair, lean back and get an idea of how it will look in an office setting. And we think once you've made your choice, you should be able to use it right away . . . not wait weeks and weeks for delivery.

Everything in the MacTavish showroom is immediately available, in quantity, from our stock. And you can take it with you right away. (Or we'll deliver it for a nominal charge.) Even better is the price tag . . . about one-third less than most places around town.

So come look . . . and do touch our merchandise.

404/458-9693
4194 N.E. Expressway at I-285

MacTavish Office Furniture
. . . the quickest way to save.

Atlanta • Dallas • Houston • Washington, D.C.

Shown above: Jasper 42 x 84 traditional executive desk and matching 21 x 84 credenza, $798 each. Prices subject to change without notice.



By the time she can have a baby of her own, will she be able to afford to?

Hospital and doctor costs for having a baby have risen from a national average of $425 in 1967 to nearly $1,150 today.

Unless something is done about it, people may see a $3,400 bill when they have a baby in 1997.

You couldn't afford that. Neither could we.

That's why Blue Cross and Blue Shield Plans, working with doctors and hospitals across the country, have introduced a number of programs designed to help slow down dramatically rising health care costs.

What we are doing to hold down rising health care costs.

Many Blue Cross and Blue Shield Plans have programs that allow qualified patients to be discharged from the hospital sooner. The hospital provides whatever medical services they need *at home*. At a cost far lower than that of an extra day — or days — in the hospital.

Under another new program, some surgical patients scheduled for a hospital stay can have their lab and X-ray tests done as outpatients. Instead of spending a $130 day in the hospital waiting for test results, the patient can return home or even go back to work until the results are in.

A third cost-cutting program in many areas is encouraging certain kinds of surgery to be performed on an "in by nine, out by five" basis. By getting the patient back home the same day, it's easier on him. And on his pocketbook, too.

We're also working with doctors' review committees to make sure that the medical procedure and tests provided are really needed. It's a cooperative effort that's saving us all millions of dollars each year. And we're also working with various planning agencies to help make sure only needed services are available.

All of these are steps that can help hold down rising health care costs. Whether or not they will depends on the cooperation of each and every one of us.

What you can do to help.

The closer you watch every health care dollar, the less increase you may have in the rates you pay for health coverage. Ask for — and *use* — the kind of cost-cutting programs we've described here.

Because only if doctors and hospitals realize that *you* are as vitally concerned as we are — and they are — will these programs be offered and used on a widespread basis.

You can also join the more than 90 million people who subscribe to not-for-profit Blue Cross and Blue Shield Plans. We annually return over ninety cents of every dollar paid in for the health care of our members, and never cancel a single person because of a poor health record.

If you'd like to know more about what we're doing to hold down costs, and what you can do to help, write Box 4445, Atlanta, GA 30302 for our free booklet, "How All of Us Can Help Each of Us Hold Down Health Care Costs."

Blue Cross
Blue Shield
of Georgia
Atlanta/Columbus

All of us helping each of us.

president's letter



MAG Will Help You With PSRO

THE MONSTROSITY WE HAVE RESISTED is relentlessly bearing down on us! I am referring to the establishment of PSRO in Georgia. In keeping with the actions and decisions of the House of Delegates at our last Annual Session, your Board of Directors decided and directed that the Georgia Medical Care Foundation be the organization to apply for a planning grant to become the PSRO in Georgia. The Board of Directors of GMCF has indicated a willingness to undertake this responsibility as well. There will, of necessity, have to be some changes in the bylaws of the Foundation to accomplish this.

In view of the above actions, you may well ask "What will MAG do?" It is my opinion that MAG must develop measures whereby it can assume the advocacy role on behalf of its members when final appeals to decisions of the PSRO are made by them. I might add that studies of this approach are already being conducted by the Board of Directors of our organization.

I would like to assure each and every one of you that your officers, directors and staff are monitoring these developments very closely and will do all they can legally to maintain the patient-physician relationship that is so essential to the art of medicine. Science is short but art is long.

Sincerely,

Robert E. Perry Jr. M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia

I've Told This Before . . .

(Editor's Note: If you ever hear a strange horn blowing in the night, think twice before you conclude what it is—especially if you're running for public office! You'll see why when you read this tail shared by Dr. McDaniel. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

Horace the Mule

DR. A. ADRIAN CHAPPELL, who lives in Atlanta, read this story in *The Chowan Herald.*

He clipped it—sent a copy to Dr. J. D. Martin—J. D. sent it to Dr. John McClure, who sent it to me. I liked it so much that I have condensed it a little to fit our allotted space and pass it on to you:

Mrs. George Wood, now deceased, of Chowan County, N.C., had a mule who was named Horace. One evening she called up Dr. Satterfield in Edenton and said to him, "Doctor, Horace is sick—his stomach is all swollen up, and I wish you would come out and look at him."

Dr. Satterfield said, "Oh Fannie Lambe, it's after 6 o'clock and I'm fixin' to eat supper. He's just all blown up with gas and has the colic. Give him an enema of mineral oil and if he isn't better, I'll come out in the morning."

"But, how'll I give it to him?" she asked.

"Ah Fannie Lambe—you're a farm woman, and know all about those things. Get a piece of tube or piece of hose, put a funnel on one end, insert the other end and pour in the mineral oil. Then make him take some exercise; that sometimes unblocks the gas."

So Fannie Lambe went out to the barn and there stood Horace with his head down; he was moaning and groaning, and his stomach was so swollen, it looked like it was going to burst.

She looked around for a funnel, but the nearest thing she could see was Uncle Bill's fox hunting horn hanging on the wall. A beautiful gold plated instrument with gold tassels hanging from it. She took the horn, lubricated it with axle grease and affixed it properly. Horace paid no attention.

Then she reached up on the shelf where medicines for farm animals were kept. But instead of picking up a bottle of mineral oil, she picked up a bottle of mineral spirits (turpentine) and poured a liberal dose of it into the horn.

Horace raised his head with a sudden jerk. He let out a yell that could have been heard a mile away. He reared up his hind legs, brought his front legs down, knocked down the barn gate, jumped a five-foot fence and started down the road at a mad gallop.

Now Horace's back-side was on fire and all this exercise commenced freeing the trapped gas, so that every so often the horn would give forth a long drawn out blast.

All the dogs in the neighborhood knew that when that horn was blowing, it meant that Uncle Bill was going fox hunting, and out they dashed following Horace. It was a marvelous sight. First, Horace running at top speed, the hunting horn in a most unusual position; the mellow notes issuing therefrom, the tassels waving



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** - The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

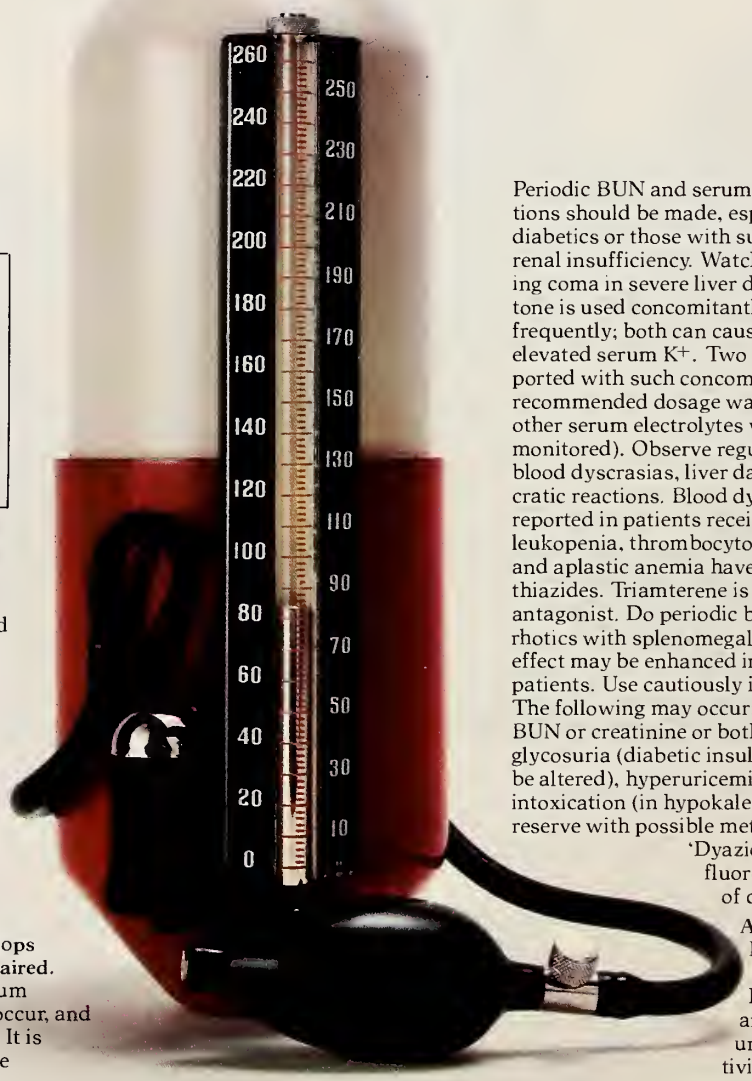
Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K⁺ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

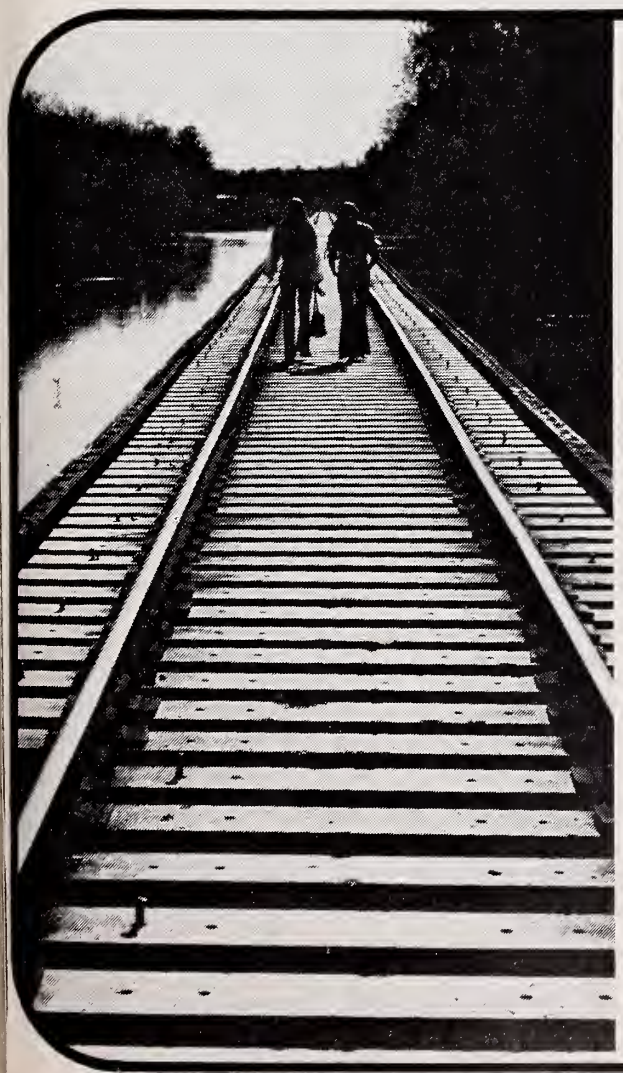
and the dogs barking joyously as they followed along.

They passed the home of Old Man Harvey Hogan, who was sitting on his front porch. He hadn't drawn a sober breath in 15 years, and he gazed in fascinated amazement at the sight that unfolded before his eyes. He couldn't believe what he was seeing. (Incidentally, he is now head of Alcoholics Anomymous in the Albemarle section of North Carolina.)

By this time it was getting dark. Horace and the dogs were approaching the inland waterway. The bridge tender heard the horn blowing and figured that a boat was approaching, so he hurriedly went out and started cranking up the bridge. Horace went overboard and many of the dogs followed him, but they all managed to swim out.

Now it happened that the bridge tender was running for the office of sheriff in Chowan County, but he managed to poll only seven votes. The people figured that any man who didn't know the difference between a mule coming up the highway with a horn up his rear and a boat coming down the inland waterway wasn't fit to hold a public office in Chowan County.

J. G. McDaniel, M.D.
820 W. Wesley Rd., NW
Atlanta, Ga. 30327



After specializing in the treatment of alcoholism and drug addiction for 17 years, we found . . .

through caring and sharing if you're willing there's a way!

Willingway Hospital

BOX 508 STATESBORO, GA 30458 (912) 764-6236

Accredited by the Joint Commission on Accreditation of Hospitals

Hormonal Therapy of Breast Cancer

J. JAY BAKER, M.D., *Atlanta**

IT IS WELL KNOWN THAT MANY PATIENTS with carcinoma of the breast may have palliation of their symptoms with the use of sex steroid hormones. It has been recently found that steroid receptor assays may be useful to the physician in choosing the most appropriate post-operative management of patients with breast cancer. In patients with metastatic breast cancer, hormone receptors may be useful as an indicator of the probable success or future failure of hormonal manipulation.

A variety of hormonal therapies have been used for metastatic breast carcinoma. Ablative therapy is aimed at removing the specific hormonal influence to which breast cancer may be responsive. This includes castration, adrenalectomy, and hypophysectomy. Additional therapy is effective through the administration of larger than physiologic concentrations of hormones.

Castration removes the primary source of estrogen as a stimulus for tumor growth in breast cancer. The adrenal glands are sources of weak androgens. They arise as intermediates in the production of glucocorticoids and mineral corticoids. These weak androgens can be metabolized to more potent androgens by the skin, brain, and breast tissue. In addition, breast cancer may convert these androgens to estrogens. Significant concentrations of estrogen may be maintained from the conversion of androgens and thereby provide a stimulus to the growth of the tumor. Adrenalectomy may lead to tumor regression by removing estrogens synthesized peripherally from the weak androgen intermediates. The pituitary gland makes a variety of growth-promoting peptides, and removal of one or more of these may

* 5675 Peachtree-Dunwoody Rd., Atlanta, Ga. 30342.
Prepared at the request of the Committee on Physician Education of the Georgia Heart Association. Articles are invited for review for publication. They should be designated as being for the Heart Page and should be addressed to the Editor of the Heart Page, care of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., NE, Atlanta, Ga. 30324.

be responsible for the response to hypophysectomy. Prolactin does not appear to support tumor growth.

The use of hormonal therapy in breast cancer is not without some complications. Surgical menopause may produce emotional difficulties, adrenalectomy and hypophysectomy carry a potential significant surgical risk and necessitate a lifetime of replacement therapy. Pharmacologic administration of sex steroids may induce significant changes in libido, cosmetic appearance, or homeostasis.

The value of estrogen and progesterone receptor assay is to identify in advance those patients who have a high likelihood of response to hormonal therapy. If the patients are lacking in receptors, then therapy may be used earlier in those patients not likely to respond to hormonal therapy, i.e., chemotherapy. It has been shown that approximately two-thirds of patients whose tumor contained hormone receptor will have objective clinical regressions following hormonal therapy. Less than 10% of those patients whose tumors lack hormone receptors will respond to hormonal manipulation, i.e., ablation or addition.

The most widely used method of hormone assay involves the use of a dextran-coated charcoal separation of tritiated hormone receptor complexes from tissue cytosol. One gram of fresh tumor tissue is required. The tissue must be trimmed of all skin, fat, muscle, and blood vessels and frozen immediately upon biopsy. The optimal use of hormone assays requires a coordination between the surgeon and the pathology department in order to obtain the tissue quickly and process it appropriately.

The use of hormonal receptor assays has been a significant advance in the treatment of patients with breast cancer. Its proper use has provided for a better selection of treatment for patients with metastatic disease.

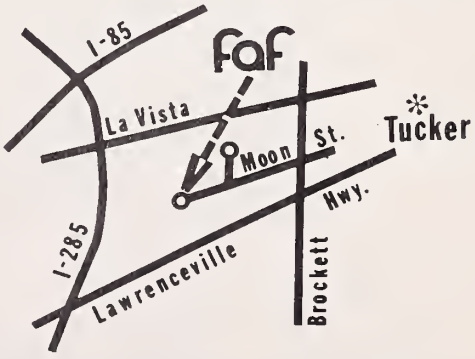


DO ALL DOCTORS DRIVE MERCEDES?

No. Some enjoy the unique experience only a Ferrari delivers.

Driving the 308GTB puts you in an entirely different world of automotive experience. To quote *Autocar*—"All round, one is lost in admiration for the superb quality of the mechanical engineering, the standard of finish of the body and interior details, and the all-round efficiency. It is the best Ferrari we have driven."

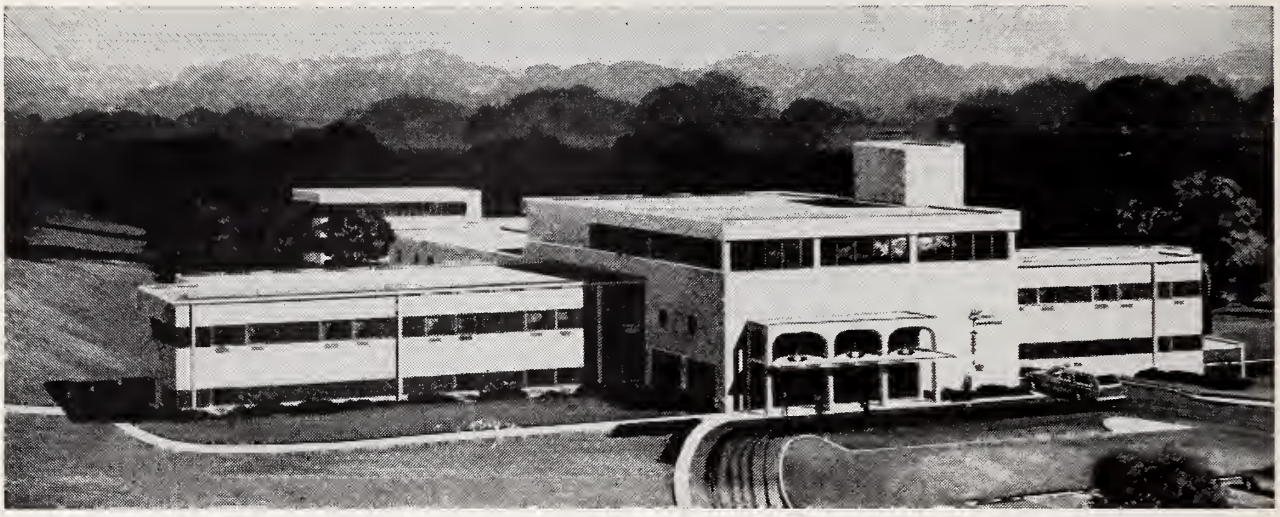
Test drive the 308GTB as our guest (it's priced about the same as some Mercedes and Porsche models). Driving will never be the same after you experience Ferrari. You will have known the Ferrari mystique.



faf motorcars inc.

AUTHORIZED FERRARI SALES • SERVICE • PARTS

3862 Stephens Court, Tucker, Ga. 30084 **(404) 939-5464**



HILL CREST HOSPITAL

FOR INTENSIVE TREATMENT OF PSYCHIATRIC DISORDERS

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR:
Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

don't look in the yellow pages...

Many of the goods and services you need are advertised in your Journal. *Below is a classified listing of companies who have advertised a minimum of three times in the past six months or who will be advertising a minimum of three times in the next six months. These advertisers make the* Journal *possible. Please help us show them our appreciation by taking a few minutes to let them know you are checking them first.*

ASSOCIATIONS
Pharmaceutical Manufacturers Association
Weight Watchers of Greater Atlanta

AUTOMOBILE DEALERS
Capital Automobile—*Cadillac*
Chris Motors—BMW
FAF Motorcars, Inc.—*Ferrari*
Hickman Datsun

BOOK PUBLISHERS
The Harrison Company

COLLECTION AGENCIES
Creditor's Mercantile

CME BOOKKEEPING
Physician's Registry

DATA PROCESSING SERVICES
Data Med Health Systems
Systemedics of Georgia

EDUCATIONAL SERVICES
Georgia Cancer Line

HEARING AIDS
Beltone Electronics

HOTELS
Omni International, *Atlanta*
Terrace Garden Inn, *Atlanta*

INSURANCE
Blue Cross and Blue Shield of Georgia/Atlanta
Dickey-Mangham Company
John Lusk
Potter-Holden & Company

INTERIOR DESIGN
River Interiors

INVESTMENT COUNSELORS
Consolidated Planning Corporation
Preferred Partnerships, Inc.

MANAGEMENT CONSULTANTS
Practice Productivity, Inc.

MILITARY
Georgia Army National Guard
U.S. Air Force
U.S. Navy

OPTICIANS
Walter Ballard

OXYGEN SUPPLIERS
Medical Oxygen Services, Inc.

PERSONNEL AGENCIES
O'Keefe Personnel

PHARMACEUTICAL COMPANIES
Armour Pharmaceuticals
Burroughs Welcome Co.
Dorsey Laboratories
Eli Lilly and Company
Merck Sharp & Dohme
Ortega Pharmaceuticals
Pennwalt
A. H. Robins Company
Roche Laboratories
Roerig
Smith Kline & French
Squibb & Sons, Inc.
The Upjohn Company
Warner Chilcott

PRACTICE OPPORTUNITIES
North Carolina Dept. of Human Resources
Qualicare, Inc.

PSYCHIATRIC HOSPITALS
Brawner Hospital, Inc.
Hill Crest
Metropolitan Psychiatric Center
Peachford Hospital
Peachtree and Parkwood Hospitals
Valley Psychiatric Hospital
Willingway Hospital

REAL ESTATE
Duluth Professional Building
Lake Arrowhead
Scott Hudgens Properties

RESTAURANTS
Bugatti
The French Restaurant
Max'
Mimi's

SCHOOLS
Woodward Academy

SILVER INVESTMENTS
William Waronker

SOFT DRINK MANUFACTURERS
Coca-Cola Company

SURGICAL SUPPLIES
Eager and Simpson
Estes Surgical Supplies

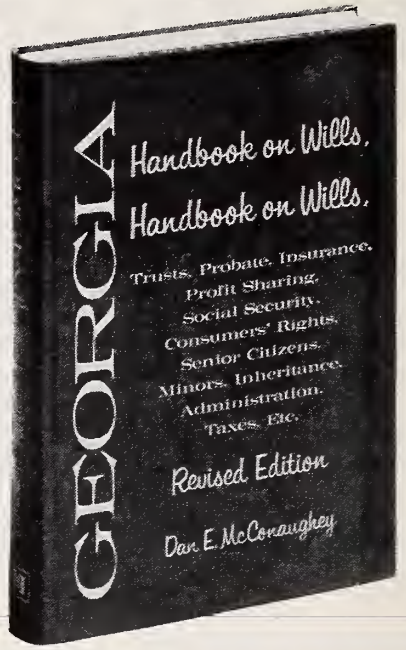
SWIMMING POOLS
Aqua-Rama

check your JOURNAL first.

The general public has more interest in the field of Wills, Inheritance, and Administration of Estates than any other field of the law.

People constantly talk about what happens when a man dies without a will — or with a Will. Does the poor widow starve to death? How does a person contest a Will? Are attorney's fees and court costs fair or outrageous? Is there some gimmick that can eliminate all of these problems?

These questions and many others are answered in this valued book based strictly on Georgia law for Georgia citizens in language easy to understand.

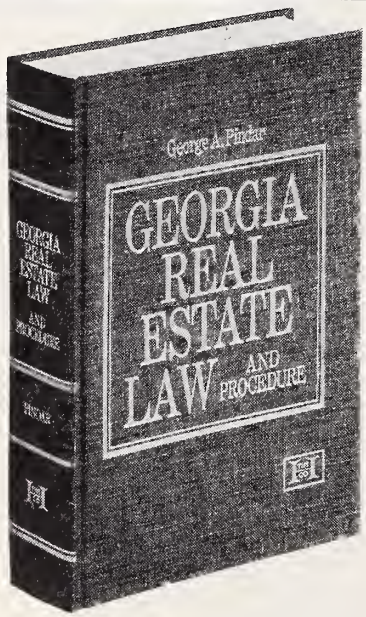


Completely updated
New chapters added

*How NOT to invest your money
*Pension and profit sharing plans
*Consumer rights
*PLUS the Tax Reform Act of 1976 is discussed

Copyright 1976, 302 pages, dimensions 6" x 9", hardbound cover in brown, yellow and orange.

An Essential Tool for anyone dealing in Georgia Real Estate



No other book provides a more detailed coverage of the Georgia Law as it pertains to every phase of real estate.

This handsomely bound book is a must for the library of every person dealing with Georgia Real Estate Law.

WITH 1977 SUPPLEMENT

Copyright 1971, 6 3/4" x 10", 1,350 pages, Hardbound. Annual pocket part supplement.

ORDER CARD

Please enter my order for the publications listed below, including supplements, revisions and related material. I understand I may at any time cancel my order for the supplements, revisions, etc., by so informing The Harrison Company in writing.

☐ McConaughey's **GEORGIA HANDBOOK ON WILLS** **$9.95**
☐ Pindar's **GEORGIA REAL ESTATE LAW with '77 Supp.** **$57.50**

Georgia Residents Add 3% Sales Tax
(Add 1% MARTA or Local Option Sales Tax to all above prices where applicable)

Cash Sales are shipped postpaid. ALL OTHER SALES will have actual postage OR freight charges added.

Prices Subject to Change Without Notice

☐ Bill Personal Account ☐ Bill Firm Account
☐ I enclose check or money order for $_____

Please Charge My ☐ BankAmericard ☐ Master Charge

your BANKAMERICARD welcome

master charge THE INTERBANK CARD

MY BANK CREDIT CARD NUMBER IS

INTERBANK NO. ____ EXP. DATE MO. YEAR

Name _____
Address _____
City _____
State _____ Zip _____
Date _____ Signature _____

ALL ORDERS MUST BE SIGNED 77-5S

THE HARRISON COMPANY, PUBLISHERS
3110 Crossing Park • Norcross, Georgia 30071 (404) 447-9150

The Staff Physician's Negligence: When Is the Hospital Liable?

RICHARD H. VINCENT *and* CHARLES STODGHILL, *Atlanta**

Respondeat superior IS THE LEGAL theory by which employers are held responsible for the wrongful acts of employees, if such acts are committed within the scope of employment. Under this doctrine, hospitals have been held liable for the negligent acts of physicians whom they employ.[1] However, in those cases where doctors with hospital staff privileges are considered independent contractors rather than employees, the hospital usually escapes liability.[2] The recent case of *Overstreet v. Doctors Hospital*[3] adds to the developing case law in this area.

As a general rule, physicians are held to be independent contractors and a hospital is not liable for their negligence "if such negligence relates to a matter of professional judgment on the part of the physician and the hospital does not exercise and has no right to exercise control in the diagnosis or treatment of an illness or injury."[4] This rule was applied in the case of *Pogue v. Hospital Authority of DeKalb County*,[5] where the court held that the hospital was not liable for the negligence of a physician; the contract between the hospital and the partnership of doctors which staffed its emergency room expressly provided that the relationship was that of employer-independent contractor rather than employer-employee. Furthermore, the hospital had claimed no right to exercise control over the method of treatment employed by the doctors but merely required that the services be performed to the satisfaction of the hospital authority and in accordance with good medical practice. The authority did retain the right to oversee the doctors' work but could not "direct specific medical techniques in rendering the services."

In contrast to the *Pogue* case, the Georgia Court of Appeals in *Hodges v. Doctors Hospital*[6] refused to hold a hospital not liable as a matter of law for the negligent acts of a staff physician, *where the degree of control exercised by the*

* Prepared at the request of The Medical Association of Georgia. Mr. Vincent is a partner and Mr. Stodghill is a Summer Associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association.

hospital was unclear. Here, the doctor worked in the emergency room in order to retain his staff privileges, but the evidence was unclear as to whether the hospital had the right to direct the method of treatment he provided to patients. The evidence showed that the hospital required the physicians to work in the emergency room and exercised control over them to that extent. Under the circumstances, the Court of Appeals held that the trial court should have let the jury determine whether the degree of control exercised by the hospital was sufficient to establish an employer-employee relationship.

The recent *Overstreet* case also involved a patient's claim that he had suffered injuries as a result of negligent treatment received during a visit to the hospital's emergency room. The emergency care at the hospital was provided by physicians employed through an independent agent, the Director of Emergency Room Services, who was under contract with the hospital. The Director was required to provide 24-hour staffing of the emergency room by doctors acceptable to the hospital's requirements. In turn, the hospital agreed that it would not exercise any control over the means employed by the Director, but would hold him responsible as to the results of the services provided being consistent with the existing standards of the profession. The court held that the physician was an independent contractor over whom the hospital had no right to direct the method of treatment used, and that, therefore, under the *Pogue* rationale, the hospital could not be held liable for his negligence.

The determining factor in all these cases seems to be the amount of control held by the hospital over doctors on its staff. If the hospital assumes the right to control the time, manner and method of treatment, as distinguished from the right merely to require certain definite results in conformity with the contract, then an employer-employee relationship will be created.[7] The important consideration is not whether the hospital actually exercised control but, rather, whether it retained the right to do so.[8] In *Overstreet,* as in *Pogue,* the hospital clearly had not assumed control over the method or manner of treatment administered to patients in its emergency room. The physicians were not directly responsible to the hospital, but to the Director of Emergency Room Services, an independent agent. The doctors were paid from the fees which were collected by the Director.

In many instances, however, the question is not so easily determined. Many doctors work at hospitals under rather loose arrangements which are difficult to describe. Often the question of control is not discussed at the time the doctor begins work and it is never fully defined during the course of his relationship with the hospital. In such cases, it is exceedingly difficult to determine as a matter of law that the hospital did not reserve control. At a matter of fact, where one is employed to perform certain services for another, and there is no specific contract to do a certain piece of work according to specifications, it is inferable that the employer has retained the right to control the manner and methods of performance.[9] In such circumstances, courts will decline to rule out an employer-employee relationship and will permit the trier of fact to examine all the facts and make a determination, which sometimes may be contrary to what both parties intended.

In order to avoid this result and to allow the parties themselves to determine who will accept responsibility for errors in patient treatment, it is advisable for hospitals and doctors to define in writing the terms of their relationship as clearly as possible.

NOTES

1. *Clary v. Hospital Auth. of Marietta,* 106 Ga. App. 134, 126 S.E.2d 470 (1962).
2. *Hodges v. Doctor's Hosp.,* 141 Ga. App. 649, —— S.E.2d —— (1977).
3. No. 53860 (Ct. App., June 30, 1977).
4. *Clary v. Hospital Auth.,* 106 Ga. App. at 135, 126 S.E.2d at 471.
5. *Pogue v. Hospital Auth. of DeKalb Co.,* 120 Ga. App. 230, 170 S.E.2d 53 (1969).
6. 141 Ga. App. 649, —— S.E.2d —— (1977); see also *Newton County Hospital v. Nickolson,* 132 Ga. App. 164, 207 S.E.2d 659 (1974).
7. *Hodges v. Doctor's Hosp.,* supra.
8. *Hodges v. Doctor's Hosp.,* supra.
9. *Travelers Ins. Co. v. Moates,* 102 Ga. App. 778, 117 S.E.2d 924 (1960).

NEW MEMBERS

Andrews, John R., Hall—Act—R
Lanier Park Hospital, Gainesville 30501

Ajoy, Vicente R., Cobb—Act—OS
625 West Memorial Dr., Atlanta 30132

Averett, Jack M., Muscogee—Act—IM
2300 Manchester Expressway, Columbus 31901

Bedizel, Mentin, MAA—Act—PD
2351 Bolton Rd., NW, Atlanta 30318

Brett, Miles E., Cobb—Act—FP
Suite 307, 2550 Windy Hill Rd., Marietta 30067

Broyles, John A., MAA—Act—D
3312 Piedmont Rd., NE, Atlanta 30305

Caballero, Ludivina, South Georgia—Act—PD
East 16th St., Alma 31510

Cabot, Anthony, Cobb—Act—ORS
Suite 101, 3903 South Cobb Drive, Smyrna 30080

Christian, Eugene E., Baldwin—Act—P
Georgia War Veterans Home, Vinson Bldg.,
Milledgeville 31062

Davidson, Jonathan R., Cobb—Act—P
3188 Atlanta St., SE, Smyrna 30080

Ellis, John W. Jr., Cobb—Act—FP
1567 Dunwoody Highway, Dunwoody 30338

Fernandez, Jose M., Cobb—Act—PD
Suite 107, 2550 Windy Hill Rd., Marietta 30062

Hothem, Arden L., Hall—Act—PS
1518 Burns Ave., Gainesville 30501

Kaleida, Phillip H., Hall—Act—PD
Suite E, 1109 Burleyson Rd., Dalton 30720

Kaplan, Gary, Cobb—Act—N
Suite E, 1678 Mulkey Rd., Austell 30001

Kitchin, Houston W., Stephens-Rabun—Act—GP
P.O. Box 1144, Clayton 30525

Matucan, Napoleon G., Decatur—Act—R
1500 East Shotwell St., Bainbridge 31717

Mendolsohn, Kevin B., Cobb—Act—OTO
1676 Mulkey Rd., Austell 30001

Milestone, Ronald, Cobb—Act—P
3188 Atlanta St., SE, Smyrna 30080

Morgan, Stephen M., Clayton-Fayette—Act—GP
259 Arrowhead Blvd., Court A, Jonesboro 30236

Morrison, James P., Crawford W. Long—Act—PD
489 North Milledge Ave., Athens 30601

Negri, Francisco Jose, Cobb—Act—TS
Suite C, 1678 Mulkey Rd., Austell 30001

Payton, John A., Stephens-Rabun—Act—FP
800 East Doyle St., Toccoa 30577

Perlstein, Susan S., MAA—Act—P
3400 Peachtree Rd., NE, Atlanta 30326

Pine, Jeffrey R., MAA—Act—PUD
1365 Clifton Rd., NE, Atlanta 30322

Poehlman, John H., Whitfield-Murray—Act—IM
1308 Memorial Dr., Dalton 30720

Rahman, Afroz, Peach Belt—Act—PD
1120 Morningside Dr., Perry 31069

Rubin, Roy M., Cobb—Act—ORS
Suite 301, 2550 Windy Hill Rd., Marietta 30067

Smith, Randolph R., Richmond—Act—PS
PO Box 1247, Medical College of Ga., Augusta 30902

Smith, Rodney, MAA—Act—CLP
1191 Winding Branch Cir., Dunwoody 30338

Soules, Virginia G., MAA—Act—OS
317 9th St., NE, Atlanta 30309

Stallings, William P., MAA—Act—D
2732 A. Felton Dr., East Point 30344

Stem, William Converse, Cobb—Act—ORS
754 Cherokee St., Marietta 30060

Taffel, Bruce H., MAA—Act—OBG
960 Johnson Ferry Rd., NE, Atlanta 30342

Thomas, W. Kevin, MAA—Act—OPH
5675 Peachtree-Dunwoody Rd., Atlanta 30342

Tong, Kun Yuan, Dougherty—Act—OBG
Suite 101, 1009 North Monroe Rd., Albany 31701

Vassadi, Rama Rao, Walton—Act—PM
924 West Spring St., Monroe 30655

Warnock, Ralph P., Upson—Act—FP
208 Cherokee Rd., Thomaston 30286

Williams, Royce M., South Georgia—Act—OBG
101 A. E. Dame Ave., Homerville 31634

Zoercher, Phillip, Hall—Act—OTO
304 South Enota Dr., NE, Gainesville 30501

Estes Surgical Supply Company

—SINCE 1908—

EXAMINATION FURNITURE
OFFICE FURNITURE
LAB SUPPLIES
ELECTROCARDIOGRAPHS
PHYSIOTHERAPY APPARATUS
SURGICAL SUPPLIES & INSTRUMENTS
SUNDRIES
X-RAY SUPPLIES
COMPLETE OSTOMY LINE

351-2011
890 CHATTAHOOCHEE AVE., NW
(NEAR I-285 & I-75 N.)

Serving the General Insurance needs of the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

SOCIETIES

On September 15, **Auxiliary to the Georgia Medical Society** opened a medical museum, a museum which exhibits antique medical instruments and devices. The exhibit, for the present, is located in the lobby of Candler General Hospital. Among the items included in the exhibit are a sterling silver tongue depressor, an antique bullet probe, and blood-letting kits.

The **Georgia Medical Society** conducted an Athletics Injuries Symposium on July 29 at the Georgia Medical Society Building. Speakers for the evening included: Paul F. Jurgensen, M.D., who spoke on physical examination of the athlete; Herbert F. Sanders, M.D., who spoke about head injuries, and Dr. H. Clark Deriso, who spoke about knee injuries. Dr. O. Emerson Ham Jr., president of the Society, conducted the ceremonies.

The **Richmond County Medical Society** has established a committee dealing with the "medical aspects of sports." The committee, which is made up of both practicing private physicians and Medical College of Georgia doctors, encourages athletic-minded high school and junior high pupils to undergo physicals at facilities provided by the committee. It also is striving to insure that every high school in Richmond County has a doctor assigned to football teams.

PERSONALS

Second District

John Daniel Bateman, M.D., of Albany, has been elected by the Hospital Corporation of America to serve on its Board of Governors, a national group of physicians who advise management on professional medical, and technical matters.

Joseph M. Turner, M.D., a specialist in internal medicine and cardiology in Tifton, is the new President-elect of the Georgia Heart Association. Dr. Turner is past chairman of the Georgia Society of Internal Medicine and member of the board of directors of the Georgia Chapter of the American College of Physicians.

Third District

Columbus physician, **William L. Amos Jr., M.D.,** has been named to the board of directors of the American Family Corporation and the American Family Life Assurance Co. Dr. Amos will also serve as vice-president and medical director for the company.

W. P. Durham, M.D., of Abbeville, has donated a specimen of stillborn Siamese twins to the Emory University School of Medicine. He delivered the twins in 1915 and had maintained the specimen since that time. A 91-year-old eye, ear, nose and throat specialist, Dr. Durham is currently retired and living in Abbeville.

Fourth District

Alexander Haraszti, M.D., a native Hungarian now living in Jonesboro, who was instrumental in arranging for Dr. Billy Graham to hold a series of religious meetings in Hungary, accompanied Dr. Graham as an interpreter when the evangelist made a trip to that country in September.

Fifth District

Professor of Rehabilitation Medicine at Emory University, **Robert L. Bennett Jr., M.D.,** received the Physician of the Year award from the President's Committee on Employment of the Handicapped at the 37th annual American Medical Association Congress of Occupational Health held in St. Louis in September. Dr. Bennett, who received the first Master of Science degree in Physical Medicine ever given by a university in the United States, was chosen for the award because of his outstanding contributions toward employment of handicapped persons.

Spencer B. King III, M.D. of the Emory University School of Medicine in Atlanta, was elected to a three-year term on the Georgia Heart Association's board of directors.

Nanette K. Wenger, M.D., of Atlanta, has been elected president of the Georgia Heart Association, the first woman ever to receive such an honor. Dr. Wenger, who is an internationally recognized expert in the field of cardiology, is professor of medicine (cardiology) at Emory University School of Medicine and director of the cardiac clinics at Grady Memorial Hospital in Atlanta. **Mark E. Silverman, M.D.,** professor of medicine at Piedmont Hospital in Atlanta, was named vice president.

Sixth District

Georgia Heart Clinic director **Robert B. Copeland, M.D.,** of LaGrange, was elected to a three-year term on the Georgia Heart Association's board of directors.

Ridley M. Glover, M.D., of Dublin, was awarded a Certificate of Special Recognition for his early leadership activities in the formation of the group Health Systems Agency of Central Georgia.

Seventh District

J. Gordon Barrow, M.D., of Douglasville, and **Paul E. Cundey Jr., M.D.,** of Augusta, were elected to a three-year term on the board of directors of the Georgia Heart Association.

Rome physician **Thomas S. Harbin Sr., M.D.,** has been elected by the Hospital Corporation of America to serve on its Board of Governors.

AUXILIARY REPORT TO MAG BOARD OF DIRECTORS, SEPTEMBER, 1977

The Annual Convention of the AMA was in San Francisco, but the distance did not deter the Georgia Auxiliary delegates. With eight delegates and seven alternates, your Auxiliary reports full representation with great pride. The Auxiliary appreciates this opportunity to offer congratulations to Dr. Harrison Rogers; the AMA has never had a more qualified vice-speaker in its history.

The Summer Executive Board Leadership Conference was held in Rome, July 11-12, 1977. This was no social occasion, as all the county presidents, presidents-elect, chairmen and state officers and chairmen will quickly inform you. After our welcome by Dr. Russell E. Andrews, chairman of the MAG Committee to the

HICKMAN DATSUN
ATLANTA HEADQUARTERS
5211 PEACHTREE INDUSTRIAL BLVD.
2 MILES INSIDE I-285
Phone 455-1122

DATSUN 280-Z
We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND...
We have the South's best service for the whole Datsun Line!

Practice where the big premium is on medical care.

Not on high overhead. Or paperwork. Or any of the other hassles that keep chipping away at your clinical time.

If you want more out of your medical career, consider what the Navy can offer. A ready-made practice where patients' medical care is independent of the fluctuations of the economy. An engaging life-style. Adventure. Travel. And as much as $30,000 to $40,000 a year to start.

This year the Navy needs General Practitioners for the Flight Surgeon program, for Undersea Medicine, and as General Medical Officers. We also need specialists in Anesthesiology, Family Practice, Psychiatry, Internal Medicine, Neurology, Radiology, Pathology, and Pediatrics. If your interests lie in any of these clinical areas, and you'd like to get back to pure medicine, the Navy is for you. Get all the facts from your local Navy medical recruiter.

Fewer than 200 physicians are needed, so don't delay.

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

THE HILTON HEAD HOSPITAL

invites you to attend a

Professional Symposium on Weight Control

December 2, 1977

on

Hilton Head Island, S.C.

Registration Fee
$100

Check should be mailed to Dr. Peter Miller, Director of Weight Control Center, Box 1117, Hilton Head Island, South Carolina 29928. Attendance limited to first one hundred registrants.

Accommodations
$10 per day

Drastically reduced weekend rate includes accommodations for both participant and spouse at the Hilton Head Inn. Arrival should be Thursday evening, December 1, with departure on Sunday, December 4.

SPEAKERS

Jerome L. Knittle, M.D., Professor and Director
Division of Nutrition and Metabolism
Mount Sinai School of Medicine, City University of New York
New York, New York
TITLE: "Adipose Tissue Development in Man"

Buris R. Boshell, M.D., Professor and Medical Director
Diabetes Research and Educational Hospital
Department of Medicine, University of Alabama School of Medicine
Birmingham, Alabama
TITLE: "Carbohydrate, Fat, and Protein in Relationship to Weight Reduction"

Todd Rogers, M.S.
Weight Control Project, Pennsylvania State University
University Park, Pennsylvania
TITLE: "Behavior Modification in the Treatment of Obesity"

Peter M. Miller, Ph.D., Director
Department of Behavioral Medicine and Weight Control Center
Hilton Head Hospital
Hilton Head Island, South Carolina

Moultrie D. Plowden, Administrator, Hilton Head Hospital
Hilton Head Island, South Carolina

For more information, contact Dr. Peter M. Miller, Hilton Head Hospital, Baygall Road, P. O. Box 1117, Hilton Head Island, S.C. 29928 (803) 785-6122.

Auxiliary, our program was immediately underway.

Mr. Charles Templeton enlightened us about how the Auxiliary could assist MAG and MAG most certainly assists us! Health education in public schools was covered by Dr. Steve Daniel. Members were given information concerning GaMPAC and legislation. A Parliamentary Procedure Workshop was led by Mrs. Ben H. Johnson, the AMA Auxiliary Constitution and By-Laws chairman. A Treasurers' Workshop and other committee meetings were scheduled in the "free" two hours before dinner, where we received instructions in "Confidence and Communication."

Tuesday morning we reconvened to hear Mrs. Dean Dickens Going and Mrs. Marion Crusselle from the Georgia Safety Council. They informed us of safety programs available for Auxiliary use in our communities—and there are numerous ones. Two films were viewed to give an idea of some of the new programs.

Douglas Talbott, M.D. and Marshall Follo, M.D. explained the Disabled Doctors' Program.

The information and ideas exchanged at the Legislative Seminar have been implemented in the feedback to the county auxiliaries. Thank you for including the Auxiliary in the meeting.

Ralph Waldo Emerson said "Nothing great was ever achieved without enthusiasm." Well, that enthusiasm is radiating from the Georgia Auxiliums, so who knows what goals will be obtained this year and in the future!

Mrs. Russell E. Andrews
President
Auxiliary to the Medical Association of Georgia

DOCTOR, LAWYER INDIAN CHIEF

Whatever your profession let us assist in making your home, office (or teepee) a perfect reflection of your taste and needs.

River Interiors is a professional interior design firm with exciting ideas plus practical know-how.

Do you want to spruce your space up a bit? Start fresh from scratch? Or want a new look using pieces you already have? River Interiors can do it with distinction and within your budget.

Interior design improvements are very personal. So we will make house calls to discuss your particular needs----- one professional to another. Consultation without obligation.

Call now for an appointment: 434-0828.

River
interior design

Smyrna, Georgia.

DEATHS

Elliott A. Ackerman

Decatur physician Elliott A. Ackerman, M.D., 41, died September 30 when his private plane crashed on takeoff at the Stone Mountain Airport. Dr. Ackerman, a 1961 graduate of the Emory University School of Medicine and an Air Force veteran, was chief of orthopedic surgery at the Veterans Administration Hospital in Atlanta.

He is survived by his wife, Mrs. Katherine Gates Ackerman, two daughters, his son, and his mother.

Carl Wilton Lupo

Carl Wilton Lupo, of St. Simons Island, died September 3 at the age of 84.

Dr. Lupo, a 1917 Vanderbilt University School of Medicine graduate, served in the Army Medical Corps with the American Expeditionary Forces in France during World War I and later with the American Red Cross Commission in Russia and the Baltic states. He received, among other military decorations, the Knight of the White Rose of Finland in 1921.

He is survived by his wife, Mrs. Mary Bucalo Lupo, two sons and three sisters.

Paul Thurmond Scoggins

Commerce physician Paul Thurmond Scoggins who served for many years on the Council of MAG, died September 14 at the age of 74.

Dr. Scoggins, who graduated from the Medical College of Georgia and settled in Commerce in 1929, served as mayor of that city for two terms and, this year, was presented a "certificate of distinction" for 50 years in practice by the Medical Association of Georgia.

Survivors include his wife, Ruth Mitchell Scoggins, a daughter, two sons, a step-daughter, two brothers, and 13 grandchildren.

W. L. Thomason

W. L. Thomason, M.D., a retired physician formerly with Crawford W. Long Memorial Hospital, died September 7 at the age of 81.

Dr. Thomason was a graduate of Emory University Medical School.

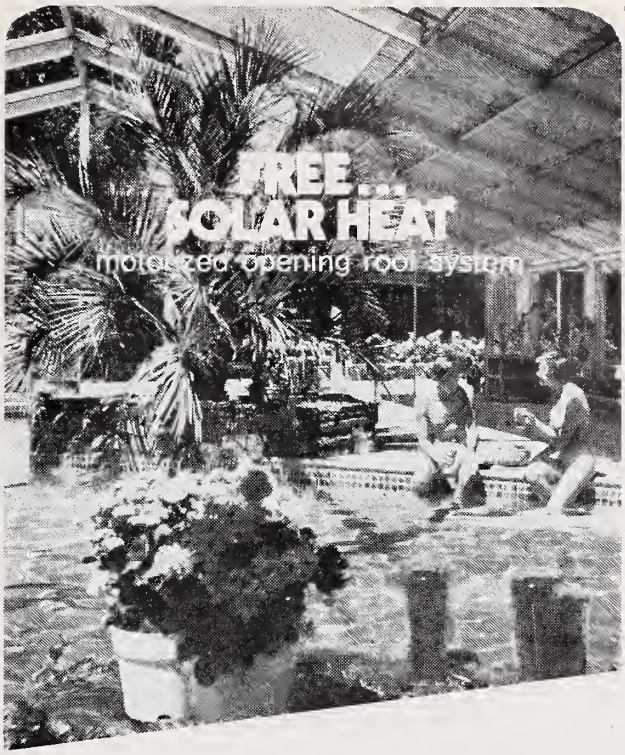
Surviving are his daughter, a son, and two sisters.

Jimmy G. Woodward

Jimmy G. Woodward, M.D., 53, of Dahlonega, died September 16, following a brief illness.

A native of Dahlonega and a 1951 graduate of the Medical College of Georgia, Dr. Woodward served for several years as chairman of the Lumpkin County Board of Health. He was awarded a citation from the American Legion Auxiliary as a community leader and for his work in the Lumpkin County Public Health program during the 1950s and 1960s.

He is survived by his wife, Beverly Fite Woodward, a son, two daughters, his mother, and his step-mother.



Welcome to the 12-month summer

A Sun/Fun enclosed pool stops the calendar at summertime. It makes the climate you want, when you want it.

With a Sun/Fun enclosed pool you can enjoy swimming all year long, day or night, any weather.

You can have more family fun, enjoy spur-of-the-moment parties, get the benefits of invigorating, healthful exercise.

Sun/Fun keeps out rain, sand, wind, insects—makes your pool a year 'round, indoor-outdoor playground for all the family.

Welcome to the 12-Month Summer!

Find out more about enclosing your present or your planned pool. Contact

SUN/FUN POOL ENCLOSURES BY

AQUA-RAMA

Complete Engineering
And Design Service
Commercial & Residential

Dealer Inquires Invited

Pools & Patio Furnishings
565 Powder Springs St.,
Marietta, Ga. 30064
Phone (404) 422-6291

Visit Our Display,
Write or Phone For Brochure

Immediate Evaluation of Athletic Injuries

Head Injuries

An early assessment of the level of consciousness is one of the most important factors in evaluating a head injury. Close, careful observation and evaluation of pupil size, weakness or dysfunction in one or more extremities, radical change in blood pressure, pulse, sensory changes, and respiratory rate are all important considerations. If conscious, the athlete should be carefully questioned to determine orientation to time, place, and substance. The conscious athlete should also be questioned about headache, visual disturbances, dizziness, nausea, memory lapses, as well as any other deviation from normal.

Each head injury should be considered to possibly have a concomitant neck injury, and, after palpating the skull, the cervical spine should also be examined. Rhinorrhea, otorrhea, or blood in the external ear canal suggest a basal skull fracture.

Whenever possible, it is important that the force that caused the head injury be known, i.e., a head hit by a golf ball would result in deformation of the skull, a knee striking the head would be likely to produce an acceleration injury of the brain, while a fall to the ground with the head striking it violently would most likely cause a deceleration injury of the brain.

Contusions of the brain are usually associated with the loss of consciousness of more than just a few moments, and individuals suffering such injuries are usually slow to clear mentally. Nausea, vomiting, persistent headache, unsteadiness, or any transient neurological deficit in addition to loss of consciousness are further evidence of severe brain injury. A laceration of the brain may not cause an immediate neurological deficit or unconsciousness, however, and concussions are not always accompanied by unconsciousness. The athlete who has suffered a cerebral concussion or other head injury rendering him unconscious, even if only momentarily, should not be permitted to re-enter the game. He should be given several days rest from vigorous activity and no contact for at least one week even if the period of unconsciousness was of brief duration and without any significant sequelae. The complete disappearance of headache, which almost inevitably follows any concussion or contusion of the brain, is a good guide as to the time when a player may return to full activity.

The use of ammonia inhalants, sedatives, and narcotics should be avoided during the immediate post-injury period. If a mouthpiece is present at the time of injury, this should be removed and the airway maintained. Judicious care in handling and transporting an athlete with a head or neck injury is essential. If comatose, the patient should be kept off his back and maintained on his side with proper positioning of head and neck so that the airway is kept patent. All significant head and neck injuries should be transferred under constant supervision as soon as possible to a hospital where further evaluation, including skull and cervical spine X-rays, and periodic reevaluation can be carried out. The level of consciousness should be monitored closely and appropriate measures taken should the patient's condition show signs of deterioration.

Knee Injuries

Injuries to the knee, considered one of the strongest joints in the body, constitute the most frequent seriously disabling injury in athletics, especially in contact sports. Following an injury to the knee, it is best to bring the athlete to the sideline without permitting him to bear weight on the injured extremity. Once on the sideline, the pants or any other clothing or protective equipment which might interfere with the examination should be removed and a careful examination made of the involved knee. Frequent comparison with the normal knee is very helpful, especially in relation to the general configuration, range of motion, and stability. An accurate diagnosis of the degree of damage is essential before making a determination of playability. The best time for accurate diagnosis of the degree of damage is at the time of injury when muscle spasm is absent, pain is not magnified, and swelling and hemarthrosis have not yet developed.

A vital aid in the diagnosis is an insight into the mechanism of the injury. Listen to the athlete's description of the injury. What is injured? Was there contact? Did he fall or did he twist? What did he hear? Was there a pop or a crack? Was there immediate disability? Was there a feeling of instability? Has there been any previous injury to the same knee? If so, what was the extent of the previous injury? Have there been any chronic symptoms since the previous injury? What is the nature and site of the pain?

Next, observe the knee. Observe the anterior-posterior and lateral alignment. Is there deformity? Is there swelling? Observe the popliteal space for any swelling. Is there muscle spasm? Is there full range of painless motion? Observe the position of

the patella. Is it high, pointing lateral, or is it normal?

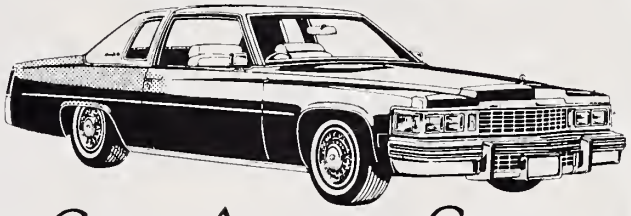
Then, examine. Palpate for tenderness along the joint line, along the various ligaments, over the pes anserina region, over the patella and the prepatellar bursa, beneath the medial and lateral surface of the patella, along the superior pole of the patella at the quadriceps attachment, along the inferior pole of the patella, and along the patella tendon to the tibial tubercle. Palpate about the fibular head and next to the fibula for any area of tenderness, and the same in the popliteal area. Note the presence of any crepitus.

Next, check the stability of the knee first in forced valgus at 0° flexion, and then in forced valgus at 30° flexion. Next, check in forced varus at 0° flexion and then in forced varus at 30° flexion. Check for hyperextension of the knee. Check for rotary instability with the knee flexed 90° and the leg internally rotated, then in mid position, and lastly in external rotation.

After careful evaluation, a safe determination can usually be made regarding the playability of the individual.

Allan J. Ryan, M.D.
Fred L. Allman Jr., M.D.
The Sports Medicine Clinic, P.C.
615 Peachtree St., N.E.
Atlanta, Ga. 30308

Capital Cadillac
SELLS AND LEASES
CADILLACS
FOR LESS THAN
ANY OTHER DEALER
IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

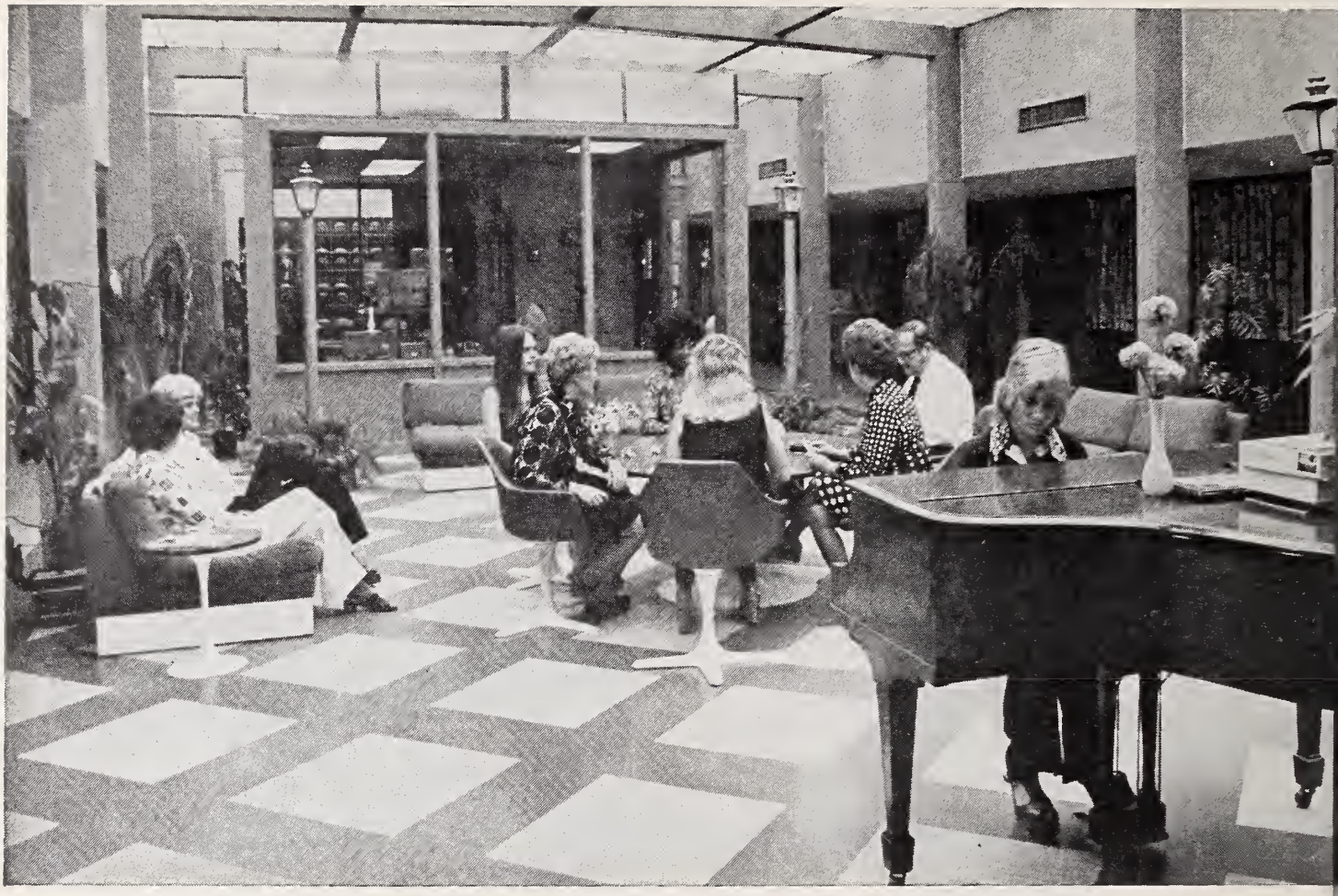
Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard



METROPOLITAN PSYCHIATRIC

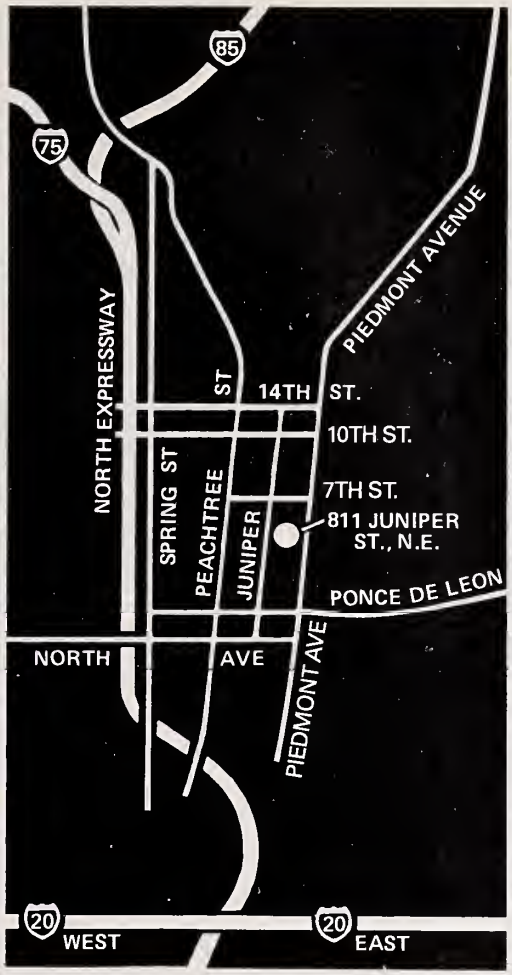
METROPOLITAN PSYCHIATRIC CENTER, central located in midtown Atlanta, provides comprehensiv services for adult and adolescent patients in the are psychiatry and alcohol and drugs. Inpatient care, outpatient care and partial hospitalization programs r available at the Center.

In the Psychiatric Program, the attending psychiatri determines from the comprehensive services availab the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

mily Counseling
ychological Testing
cial Work Services
lucational Tutoring
cational Rehabilitation Counseling
ll Radiology Services
ctivity Therapy Programs including Occupational
erapy, Recreational Therapy and Art Therapy

Georgian Clinic Program, directed towards the
very of persons addicted to alcohol or drugs, offers a
ctured yet personalized experience drawing upon a
range of treatment modalities. Through the

Grumet, M.D.
cal Director

Custis L. Rosser, M.H.A.
Administrator

ge Dominick, M. Div.
tor, Georgian Clinic Program

combined resources of the Center for Psychotherapy Inc., the Atlanta Internal Medicine, P.A., and the Metropolitan Psychiatric Center staff, the following services are included:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling
- Pastoral Counseling Services

Additional information on the Psychiatric Program may be obtained by contacting Dottie Fitchett, Admissions. For information on the Georgian Clinic Program, call 876-8655. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

opolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

INTERNIST/FAMILY PRACTITIONER: TIRED OF CITY TURMOIL?

Lake Elsinore, which is located only one hour south of Los Angeles and one hour north of San Diego needs you now. The area offers the best of living conditions in one of the most beautiful areas of California.

Due to population growth, we are now in need of two Internists and one Family Practice Physician. We offer excellent guaranteed income for first year with free office space and household move provided. If you want a busy practice away from city pressures, write with C.V. or call:

LAKEVIEW GENERAL HOSPITAL
Chris DiCicco, Administrator
P.O. Box 489
Lake Elsinore, California 92330
Telephone: (714) 674-1421

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$5.00 for the first 50 words; $.10 per word for each additional word. **Non-members**—$15.00 for the first 50 words; $.10 per word for each additional word. *Charges are payable in advance.* Copy must be typed and received by the Publisher no later than the 25th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535, INWATS in Georgia (800) 282-0224.

PHYSICIANS NEEDED

FAMILY PRACTICE AND OB/GYN opportunity for solo or group practice in community of approximately 9,000 located in east-central section of South Carolina. Partnership arrangement guarantees $50,000. Forty-eight-bed hospital serves local area with easy access and referral to new regional medical center 20 miles away. Six FPs/GPs presently in community. Contact J. D. Whitehead, M.D., Lake City, S.C., (803) 394-2238.

FAMILY PRACTICE PHYSICIAN needed to join busy, one-man established family practice office. Twenty minutes from downtown Atlanta. Excellent opportunity. Write Box 10-A, c/o the *Journal*.

FAMILY PRACTITIONER WANTED to work into busy family practice in Metro Atlanta area (Cobb County). No investment, equipment, etc., needed. Work on percentage basis until other arrangement justified. No strings attached. For more information, call Peter J. Krebs and Associates, P.C., attorneys, (404) 321-5845.

FPs NEEDED—Growing community of 4,000+ needs one or two M.D.s, two FPs in town and one nearby. Join existing practice or solo available. Excellent rec. and econ. Sixty miles from metro cities; 57-bed JCAH Hospital in community. Trade area of 12,000+. U.S. graduate preferred. Contact L. Wattier, Administrator, Memorial Hospital, Inc., 104 West 17th St., Schuyler, Nebraska 68661, (402) 352-2441.

PSYCHIATRIST—FULL TIME—Board eligible or certified to head 40-bed in-patient active treatment unit in 300-bed state regional psychiatric hospital. Must be skilled in use of medications and interested in working with multi-disciplinary treatment team. Starting salary range $32,046 to $40,266, depending on qualifications, with liberal fringe benefit package including six months and then annual increments. Excellent location in suburb of Atlanta. Contact Charles Goldman, M.D., P.O. Box 32407, Decatur, Ga. 30032, (404) 243-2114.

EMERGENCY ROOM PHYSICIAN—450-bed general hospital, Southwest Georgia; active emergency room service. Contact Administrator, Phoebe Putney Memorial Hospital, Albany, Ga. 31702, (912) 883-1800.

REAL ESTATE

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital; 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Write Box 10-B c/o the *Journal*.

WILL SELL, IN WHOLE OR PART, 95 acres of farmland, West Cobb County near MacLand; 25-29% down, balance on any reasonable terms. Write: Physician, P.O. Box 54778, Atlanta, Ga. 30308.

GOLFERS PARADISE—Sea Palms Colony Condominium. Brick and tabby structure on historic St. Simons Island, Georgia. Overlooks the golf course, private pool and all amenities. Sleeps six, must see to appreciate. Fully furnished. Price $75,000.00 firm. Contact Conway Hunter, Jr., M.D. (404) 351-6565.

SERVICES

PHYSICIANS NEEDED for First Georgia Leasing prestige cars. Luxury and prestige 1978 cars are becoming available this month. We lease all makes, foreign and domestic. New 1977 Mercedes are super values at $265 per month for business use. Preferential rates and service to the profession. Call me personally, Tom Lawless, in Atlanta, (404) 971-8838.

PRACTICE FOR SALE

FANTASTIC DEAL for two GPs or FPs. Active and profitable practice in Sandy Springs near Atlanta for sale, including building, equipment and staff. Cash flow in excess of $1 million per year for the past seven years; building appraised at $1.2 million. The two physicians who now own the practice are retiring from medical practice but agree to stay on during transition. Price: $1 million; 100% financing available (no down payment). Contact Mr. Robin O'Brien at (404) 241-2818 or 241-7792.

MISCELLANEOUS

BACK ISSUES OF the *Journal of the American Medical Association*, January 1973 through June 1977, free to anyone who will pick them up. Call the *Journal* office of MAG (404) 876-7535; INWATS (800) 282-0224.

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

Index to Advertising

Vol. 66 October 1977 No. 10

Accounting Systems, Inc. 708
American Medical Association Scientific Meeting 771, 772
Aqua-Rama 835
Walter Ballard Optical 840
Blue Cross and Blue Shield 818
Brawner Hospital, Inc. 758
Burroughs Wellcome Co. 809
Capital Automobile Company 837
Chris Motors 814
Classified Advertising 841
Consolidated Planning Corporation 808
Creditor's Mercantile 804
Credit Rating Bureau 806
Data Med Health Systems 790
Dickey-Mangham Company 840
Eager and Simpson 781
Estes Surgical Supply Company 832
Faf Motorcars 825
Harrison Company 828
Hickman Datsun 833
Hill Crest Hospital 826
Hilton Head Hospital 834
Lake Arrowhead 767, 787
Eli Lilly and Company 764
MacTavish Office Furniture 817
Medical Oxygen Service, Inc. 776
Metropolitan Psychiatric Hospital 838, 839
Nixdorf Computer, Inc. 794
Ortega Pharmaceutical Company 795
Peachtree and Parkwood Hospitals 782
Pennwalt 810, 811
Pharmaceutical Manufacturers Association 812, 813
Potter-Holden & Company 832
Practice Productivity, Inc. 796
Preferred Partnerships, Inc. 757
Qualicare, Inc. 840
River Interiors 834
Roche Laboratories 756, 843, 844
Roerig 760, 761, 821, 822
Squibb & Sons, Inc. 797, 798, 799, 800
Systemedics of Georgia 808
U. S. Navy 833
Valley Psychiatric Hospital 837
Warner Chilcott 762
Weight Watchers of Greater Atlanta 840
Willingway Hospital 823

JOURNAL
of the medical association of georgia

938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.,** 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® Ⓘⓥ

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFI

40911 411 J
THE LIBRARY
ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

Since its discovery in the research laboratories at Roche, Li
has been the object of ongoing pharmacologic and clinical investiga

The published record on Librium is enormous. So large, in fa
put it into a computer literature retrieval system to make it more acce
in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ℞
chlordiazepoxide HCl/Roche

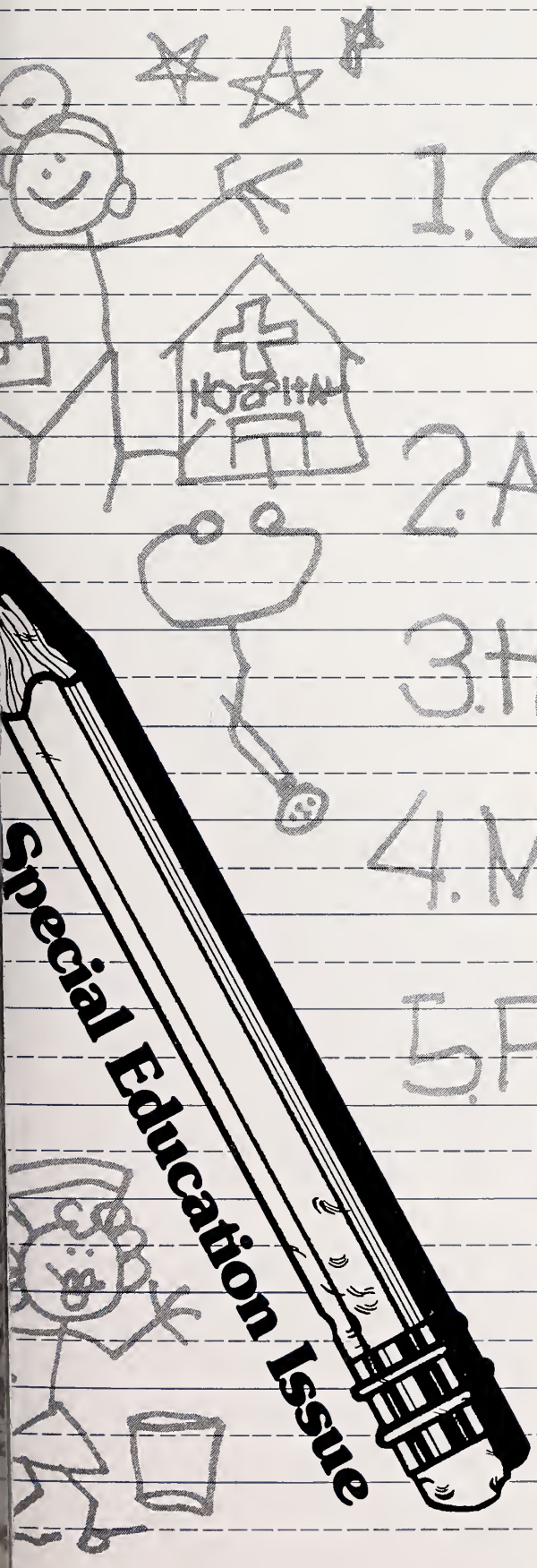


ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

JOURNAL
of the medical association of
georgia
NOVEMBER / 1977



1. Continuing Medical Education
2. Accreditation
3. Health Education
4. Medical Schools
5. Physician's Recognition Award

LIBRARY
U.C. SAN FRANCISCO
DEC 14 1977

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

don't just stand there...

When it comes to executive seating your quality office product companies don't bring up the rear. We're set up to move fast. With on-time immediate delivery on these CHROMCRAFT classics. And talk about comfort. Sit in one of our Classic chairs. You'll feel the deep-down luxury of contour molded foam cushioning. All Classic chairs are available in fire retardant vinyls and foam that meet all state and federal recommendations. At no extra charge. Classic chairs are guaranteed against structural failure for a full 12 years. Upholstery materials are guaranteed for two full years. New double-torsion tilt mechanism gives theater seat comfort. Full swivel with telescoping hand-wheel height adjustment. And the prices are right! For information, visit our showroom or call **NORTH DEKALB OFFICE SUPPLY, INC.**, 5404 New Peachtree Road, Chamblee. 404-457-2524



Brawner Hospital, Inc.

Established in 1910
3180 Atlanta Rd.
Smyrna, Ga. 30080
(404) 436-0081



Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 11

EDITOR
Edgar Woody Jr., M.D.
MANAGING EDITOR
Sharon T. Smith
ASSISTANT MANAGING EDITOR
Caffilene Allen
ADVERTISING MANAGER
Mary Coté
BUSINESS MANAGER
L. B. Storey
CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta
PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House

THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Kenneth M. Williams, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant to the Executive Director

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.
Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SPECIAL ARTICLES

857 Liaison Between Physicians and Social Workers
Louisa W. McFadden, M.S.W., A.C.S.W.
861 A New Model for Inpatient Treatment of Alcohol and Other Drug Addictions
William F. Wieland, M.D.

SPECIAL EDUCATION SECTION

The MAG and Education
865 An Update
Steven L. Daniel, Ph.D.
Continuing Medical Education
869 How Does an Organization Obtain Category 1 Credits for Its CME Program?
James S. Maughon, M.D.
870 Preparing an Education Program in a Community Hospital
John A. Hudson, M.D.
871 Continuing Medical Education by TV Broadcasts and Videocasettes: The Emory Program
Bernard L. Hallman, M.D.
873 Accredited CME in Georgia
874 Physician's Recognition Award Recipients
876 Medical Meeting Calendar
877 The Case Against Mandatory CME
Benjamin B. Wells, M.D.
884 Continuing Medical Education at MCG
Glen E. Garrison, M.D.
Health Education in the Schools
880 The Day the Doctor Brought a Cow to School
Billy Gober, Ed.D.
Medical Schools
871 Continuing Medical Education by TV Broadcasts and Videocasettes: The Emory Program
Bernard L. Hallman, M.D.
882 The School of Medicine at Morehouse College: A Progress Report
Louis W. Sullivan, M.D.
884 Continuing Medical Education at MCG
Glen E. Garrison, M.D.
885 The School of Medicine at Mercer University
George R. Bernard, Ph.D.
County Societies and the Public
886 Educating the Public about Health and Disease; the Atlanta Health Forums, 1977
Nicholas E. Davies, M.D.
886 Public Information Efforts in Dougherty County
887 Cobb County Medical Society Symposium
889 Tel-Med: A Progress Report
J. W. Holderfield, CAE

EDITORIALS

891 Opsimathy and Other Responsibilities
LaMar S. McGinnis, M.D.

FEATURES

892 President's Letter/Education: A Primary Goal
Robert E. Perry Jr., M.D.
897 I've Told This Before/The Thoughts of Sweet Alice
Ted F. Leigh, M.D.
899 Cancer Page/Carcinoembryonic Antigen (CEA)
Mario J. R. Ravry, M.D., F.A.C.P.
903 Heart Page/Current Indications for Coronary Artery Angiography and Bypass Surgery—Part 1
Gordon C. Miller, M.D.
907 Legal Page/Regents of the University of California v. Bakke: Must Medical School Admissions Programs Be "Color-Blind"?
Robert N. Berg

THE ASSOCIATION

917 New Members
917 Societies
917 Personals
918 Deaths

NEWS

872 MAG to Conduct Survey on CME
875 Medical Meeting Calendar
918 Prudential Medicare Number Changed
919 DMA Expenditures
926 Index to Advertising
926 Manuscript Information

THE COVER

This issue of the *Journal* features a special Education Section beginning on page 865, covering several areas: the MAG and education; CME; health education in schools; medical schools, and public education. The education theme continues on the Editorial Page, page 891, in the President's Letter, page 892, and on the Legal Page, page 907.

Capital Cadillac

SELLS AND LEASES
CADILLACS
FOR LESS THAN
ANY OTHER DEALER
IN THE SOUTH . . .



CAPITAL AUTOMOBILE COMPANY
796 W. Peachtree St. N.W., Atlanta, Ga.
881-9900

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
© WEIGHT WATCHERS INTERNATIONAL, 1977

BRIEF SUMMARY OF
PRESCRIBING INFORMATION

ANTIMINTH® (pyrantel pamoate)
ORAL SUSPENSION

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

The drug has not been extensively studied in children under two years; therefore, in the treatment of children under the age of two years, the relative benefit/risk should be considered.

Precautions: Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with preexisting liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg of pyrantel base/ml) should be administered in a single dose of 11 mg of pyrantel base per kg of body weight (or 5 mg/lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 ml of Antiminth per 10 lb. of body weight. (One teaspoonful=5 ml.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth Oral Suspension is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml, supplied in 60 ml bottles and Unitcups™ of 5 ml in packages of 12.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

When you're good people recognize you.

Highly effective
Single-dose convenience
Non-staining
Economical
Pleasant tasting

Antiminth®
(pyrantel pamoate)
equivalent to 50 mg pyrantel/ml
ORAL SUSPENSION



a drug of choice in pinworm infections

Please see brief summary of prescribing information on facing page.

©1977 LONE RANGER T.V., INC.



BREATHING WITH COMFORT.

Choledyl – a highly soluble, true salt of theophylline – rapidly relaxes bronchospasm to promote easier breathing. And, gastric discomfort is minimal.

Because Choledyl is more stable...more rapidly absorbed from the G.I. tract than aminophylline.

Available in both tablets and elixir for patients with obstructive lung disease.

Choledyl® (oxtriphylline) Tablets and Elixir CAUTION: Federal law prohibits dispensing without prescription. Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. Each teaspoonful of the elixir contains 100 mg oxtriphylline; alcohol 20%. *Indications.* Choledyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema. *Warning.* Use in pregnancy – animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child. *Precautions.* Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children. *Adverse Reactions.* Gastric distress and, occasionally, palpitation and CNS stimulation have been reported. *Dosage.* Average adult dosage: Tablets – 200 mg, 4 times a day; Elixir – two teaspoonfuls, 4 times a day. *Supplied.* 200 mg yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose – 200 mg tablets (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). Elixir – bottles of 16 fl oz (1 pint) 474 ml (N 0047-0215-16). *Toxicity.* Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen. Full information is available on request.

CH-GP-51-4/C

WARNER/CHILCOTT
Division, Warner-Lambert Company
Morris Plains, N.J. 07950

CHOLEDYL® (OXTRIPHYLLINE)

SINGLE-ENTITY
BRONCHODILATION
MINIMAL GASTRIC DISCOMFORT

physicians:

we treat you seriously in the air force...

As an Air Force officer, you'll practice in a highly professional atmosphere, supported by a team of highly qualified technical assistants. You'll treat patients in your specialty in new and modern health care facilities. You'll enjoy the finest specialty training in military and civilian hospitals. The Air Force has many opportunities for unlimited professional development, with a carefully individualized plan to make the best use of your skills, knowledge, and ambition. From research to the finest in clinical medicine, our centers offer a full range of available openings. For a full-time career without the time-consuming burdens of private practice, a minimum of administrative detail, and a maximum of leisure time, consider our offer . . .

Write Today for More Information:

Capt. Bruce Geis
Suite 208, 3050 Presidential Dr.
Atlanta, Ga. 30340
Or Call Collect: (404) 451-3888

R3 find your perfect practice in the air force

4

Linde

MEDICAL OXYGEN SERVICE, INC.

WALKER DISTRIBUTOR

New Oxygen Therapy Systems for Home Use

- Pulminary Care Unit
- Oxygen Walker System

Service Centers

- Atlanta
- Albany
- Waycross

WE SELL SERVICE

- Additional literature upon request
- 935 Jefferson St., N.W. ● Atlanta, Ga. 30318 ● (404) 875-4058

Serving the General Insurance needs of the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.

Professional Liability—Umbrella—Property

YOUR ... AGENT

Practice where the big premium is on medical care.

Not on high overhead. Or paperwork. Or any of the other hassles that keep chipping away at your clinical time.

If you want more out of your medical career, consider what the Navy can offer. A ready-made practice where patients' medical care is independent of the fluctuations of the economy. An engaging life-style. Adventure. Travel. And as much as $30,000 to $40,000 a year to start.

This year the Navy needs General Practitioners for the Flight Surgeon program, for Undersea Medicine, and as General Medical Officers. We also need specialists in Anesthesiology, Family Practice, Psychiatry, Internal Medicine, Neurology, Radiology, Pathology, and Pediatrics. If your interests lie in any of these clinical areas, and you'd like to get back to pure medicine, the Navy is for you. Get all the facts from your local Navy medical recruiter.

Fewer than 200 physicians are needed, so don't delay.

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

HICKMAN DATSUN

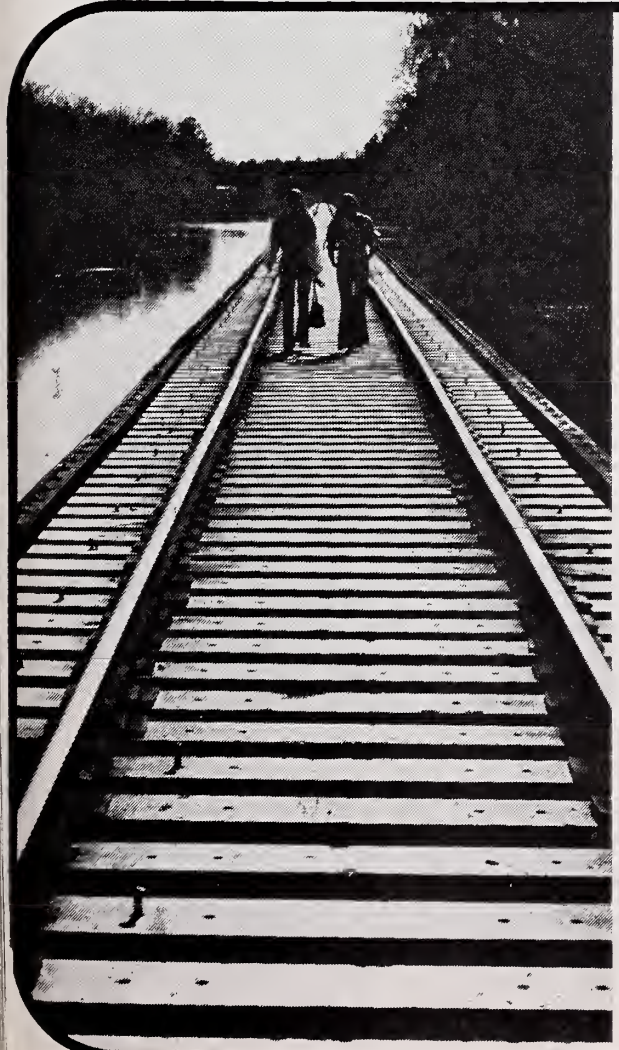
ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD.
2 MILES INSIDE I-285
Phone 455-1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND...
We have the South's best service for the whole Datsun Line!



After specializing in the treatment of alcoholism and drug addiction for 17 years, we found . . .

through caring and sharing if you're willing there's a way!

Willingway Hospital

BOX 508 STATESBORO, GA 30458 (912) 764-6236

Accredited by the Joint Commission on Accreditation of Hospitals

Kefzol® I.M./I.V.
cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin



Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

700773

JOURNAL
of the medical association of
georgia

Liaison Between Physicians and Social Workers

LOUISA W. McFADDEN, M.S.W., A.C.S.W., *Atlanta**

This paper, authored by a physician's wife, makes a plea for better communication between members of the medical team

THE TERM CHILD ABUSE continues to be as unpopular as the reality of it. Professionals in all fields, as well as the man in the street, prefer not to think about it. That children are inflicted with non-accidental traumas[1] by their parents or caretakers is a reality that is difficult to face and deal with in a society in which the fantasy of super moms and super pops still exists.

Helping persons in all walks of life have been accused of turning their heads the other way when confronted with the possibility of child abuse in a client or patient. Not only is it a horrifying thought, but suspected child abuse is difficult to handle with the child's parents. It requires a physician, social worker, or nurse, or indeed any other helping person to make an observation, which is at best accusatory, act on the observation, and, if necessary, prove it. This is both difficult and unpleasant. Even so, as Starbuck[2] said, "Accidents are socially acceptable; abuse of children is not."

Just as abuse is unacceptable, so has it always been unacceptable for social workers to presume to tell or suggest to physicians how they might do a better job. Not only have physicians been reluctant to listen to social workers who have less prestigious educations, they sometimes feel it is they who are the experts in dealing with people and problems. On the other hand, social workers have been guilty of putting physicians on a pedestal and are often in awe of the physician to the extent that they do not make the best use of the assistance the physician may offer. According to Renvoize,[3] "The myth that doctors are omniscient creatures whose wisdom is above reproach dies hard."

Feeling in, if not actually being in, a "one-down" position, the social worker may, as a consequence, become defensive in dealing with the physician. Thus, it is possible that due to each professional's self-image, either alone, or in relation to each other, liaison that might in some cases protect a child from abuse is sacrificed. Within this context, liaison is defined as the "contact maintained between units in order to insure concerted action."[4]

The following case illustration, based upon fact, may demonstrate an instance in which liaison disintegrated into something that ended in tragedy:

On a Monday evening, Mr. and Mrs. Potts took their 8-month-old son to a local emergency room where he was seen by the ER physician who questioned the child's many lacerations and bruises, all of which were in various stages of healing. The parents explained that the child, just learning to walk, had fallen down the back stairs. They then requested that the child's pediatrician be called, which was done.

The ER physician suspected child abuse on the basis of the multiple injuries of varying age (inconsistent with the parents' explanation). The physician called a protective services caseworker who arrived prior to the family's pediatrician. After talking with the ER physician and seeing the child, the caseworker also suspected child abuse.

By this time, the child's pediatrician arrived and conducted his own examination. Upon completion, the ER physician and the caseworker told the pe-

* Ms. McFadden's address is 2508 Montview Drive, NW, Atlanta, Ga. 30305. This paper came as a result of her work as chairman of the Child Welfare Advisory Committee of the Fulton County Department of Family and Children Services.

diatrician what they thought and recommended that the child be hospitalized for evaluation. They reasoned that if child abuse was a possibility, the time the child was hospitalized would be doubly purposeful: to protect the child from further abuse and to evaluate the child's injuries and his home situation. The pediatrician disagreed and refused to hospitalize the child.

The child died four days later of alleged child abuse. The local newspaper reported that the protective services workers had refused to remove the child from the home.

The above illustration gives only the skeleton details of the case and thus leaves room for all kinds of suppositions. The lack of communication in this case might have been affected by the ages of the professionals—a young caseworker and staff physician versus an older pediatrician, and all the ramifications of younger professionals "advising" an older and longer-experienced physician. Or, perhaps, the young caseworker could have called her supervisor for advice. Maybe the welfare department could have petitioned the court on the basis of information from the staff physician, which would have protected the child but might have been a breach of medical ethics to attempt to over-rule the family physician.* Finally, the family physician, after the completion of tests for exotic etiologies of the child's injuries, which were negative, might have contacted the protective services workers for assistance in dealing with a case of suspected child abuse. One might speculate all day, but the crux of the situation was that there was no useful communication between professionals, all of whom were concerned with the welfare of children. The outcome was the death of a child.

"(Sometimes) professionals . . . are more concerned with alienating parents than with protecting lives"

Lest it seem that an attack has been launched against pediatricians, or, for that matter, pediatric surgeons and neurologists, or radiologists, it is important to report another case[5] which occurred in Cleveland, Tennessee, in the spring of 1976 when welfare workers returned a four-year-old child to parents who, in 1973, had been convicted of abusing her. Several months after the child was returned, these same parents were arrested for allegedly murdering their child. A pediatrician involved in the case accused welfare officials of noncooperation in this and other cases. He noted that of 35 cases of suspected abuse that had been reported to the welfare department, seven children were now dead.

* Only courts or police officials may legally remove a child from his home.

At best, this case represents a break-down in communication between professionals. At worst, it represents no communication at all. Again, for whatever reasons, no matter how important, another child died, when perhaps she could have been saved through proper liaison between physicians and social workers.

Various explanations have been suggested for the lack of cooperation among professionals. Some blame the personalities and preconceived ideas of job function of the persons involved: social workers, supervisors, agency administrators, physicians, or hospital personnel. Some place the blame on social work education and medical school education for failing to train people in helping professions how to relate to each other on a helpful, cooperative basis. Others place blame on work situations in which professionals are over-taxed, tired, and frazzled with their own bailiwicks, to say nothing of someone else's. Renvoize[3] alludes to personal attachments professionals have to their clients or patients. Others mention confidentiality. Finally, blame might also be placed on the economy, governmental cuts in social work staff positions, and the lack of specialized training required, in some cases, for skilled social work positions.

Blame-casting is important only if something constructive is done about existing problems. Far too often, however, problems which are by nature negative are dealt with or matched by negativism—idle complaining, infighting, and inaction. Of course there needs to be an attack on the more global problems of staff shortages, economic problems, and medical and social work education. In the meantime, there are some facts that all people who deal with children need to know and act on.

1) Child abuse exists in the state of Georgia. According to the Department of Human Resources' Child Abuse Central Registry,[6] from July 1, 1975, through June 30, 1976, 885 reports of child abuse were made. Of these, child abuse was confirmed in 473 cases.

2) Of the 885 reported cases of child abuse, private physicians made 26 reports; the local Departments of Family and Children Services made six. Most reports were made by hospitals, relatives, concerned citizens, and schools.

3) Of the unconfirmed reports (885), 536 were known at some time to the local state Departments of Family and Children Services.

4) In Fulton County, ten referrals of abuse and neglect were received from private physicians in 1976.[7]

5) Georgia has a law[8] that requires physicians and social workers, as well as other professionals and paraprofessionals who work with children, to

report any suspected abuse or neglect to a child welfare agency or police authority. This law carries with it an immunity-from-liability clause, as well as a penalty for non-reporting.

6) Yet, eight Georgia children were known to be fatally abused in 1975-76.[6] There may have been others.

The numbers show, according to the *Child Protection Report,*[9] that 60 percent of abuse and neglect cases that are investigated are confirmed. This does no one any good, however, if suspected cases are not reported and if investigations are not, or, are improperly conducted. It does no good if professionals, as Rosenfield and Newberger[9] point out, are more concerned with alienating parents than protecting lives. And it does no good if physicians and social workers cannot put their heads together, help each other, and help children.

"Child abuse exists in the state of Georgia . . . most reports are made by hospitals, relatives, concerned citizens, and schools"— not by physicians and social workers

If even one child dies because of lack of cooperation between physicians and social workers, then this is an ominous problem. Liaison should be something professionals can accomplish in the here and now. And, for the sake of the children, it is something we have to do.

REFERENCES

1. Helfer, R. and Kempe, Henry C. (ed.): *The Battered Child,* Chicago, University of Chicago Press, 1968.
2. Starbuck, George W.: The recognition and early management of child abuse, *Pediatric Annals,* 5:146-155, March 1976.
3. Renvoize, Jean: *Children In Danger,* London, Routledge and Kegan Paul, Ltd., 1974.
4. Stein, Jess (ed.): *The Random House Dictionary of the English Language* (unabridged), New York, Random House, Inc., 1966.
5. Waycross Journal-Herald: The horror of child abuse, *The Atlanta Constitution,* November 5, 1976.
6. Department of Human Resources, State of Georgia: Child abuse central registry (statistical summary), July 1975-June 1976.
7. Annual Report, Fulton County 24-Emergency Services, 1976.
8. 1977 Georgia Law, Code Section 74-111.
9. Howard, William E. (ed.): *Child Protection Report,* 2:1-6, November 1976.

SALE PRICE ONLY WITH COUPON

TEAK BOOKCASE SALE



Regularly $119.95, now

$89.95*

32"W x 12"D x 72"H

Also available in a variety of other sizes in TEAK and WALNUT at similar savings:
24" Wide thru 48"W
32" High thru 76"H
12" Deep thru 18"D

Don't miss this unusual opportunity to purchase fine Scandinavian craftsmanship at our Annual Bookcase Sale. Doors open 10:00
*Unassembled for easy transporting.

VISA, MASTER CHARGE and C&S cards welcome.

designhouse international

ATLANTA LOCATIONS: (Area Code 404)	CUMBERLAND MALL 434-3000	CHESHIRE BRIDGE 874-0636	NORTHLAKE MALL 939-9365	N.E. EXPRESSWAY 449-6636

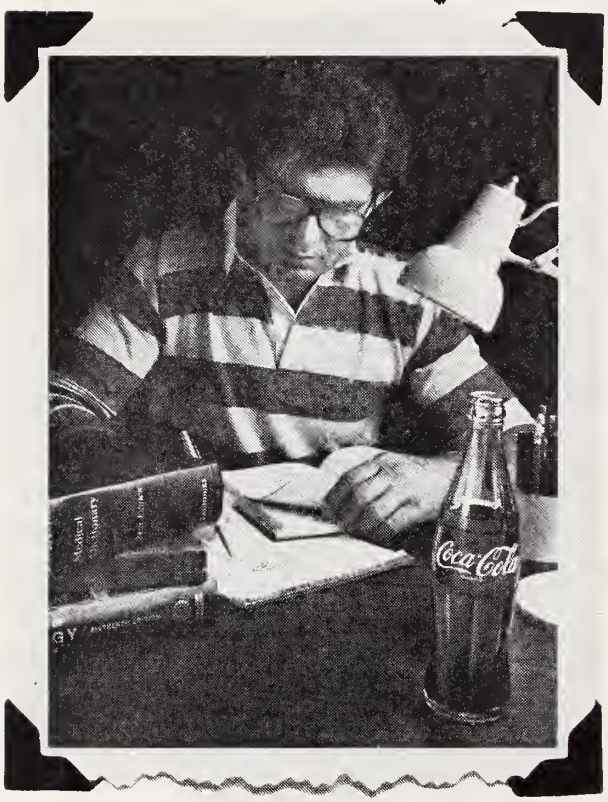
SAVE WITH THIS COUPON

SAVE WITH THIS COUPON

BRING THIS COUPON WITH YOU

Coke adds life to... those special moments.

Trade-mark®



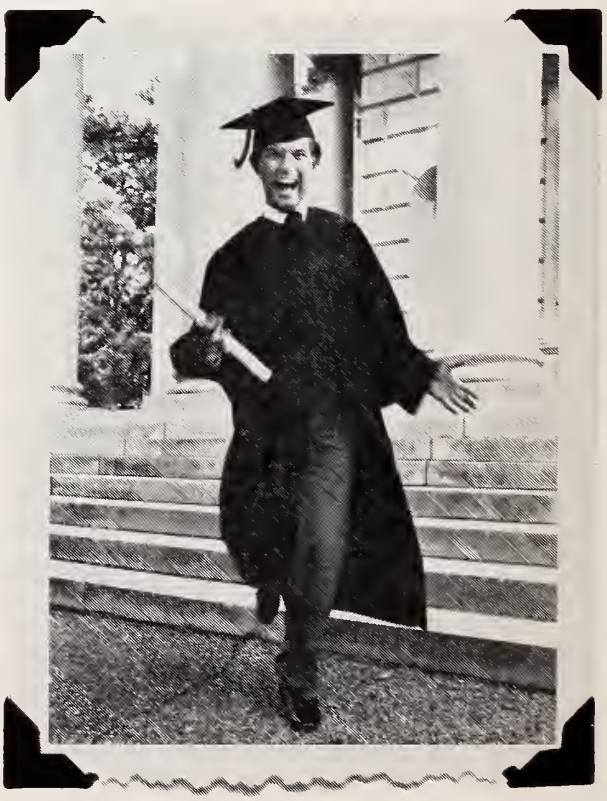
June 2: 2 A.M. Me! Cramming for Inorganic Chemistry finals. Man was I beat!



Sunday, May 2: My first date with Jan at the lake.



May 26: Inter-Fraternity Council Championship. We won 7-6!



June 15: Today, I graduated!

"Coca-Cola" and "Coke" are registered trade-marks which identify the same product of The Coca-Cola Company.

It is widely acknowledged that recovery is a long-term—even a lifetime—process, so sound planning for continuing care is essential

A New Model for Inpatient Treatment of Alcohol and Other Drug Addictions

WILLIAM F. WIELAND, M.D., *Smyrna**

A PERSISTENT CONTROVERSY in the treatment of alcoholism and other drug addictions surrounds the definition of the functional role and relative value of hospitalization. At one extreme are the advocates of outpatient detoxification, with or without supportive medication, who argue that such methods are just as successful (or unsuccessful) as inpatient treatment and that the costs are substantially lower. Further, they feel that outpatient treatment is less disruptive to family life and employment and is less apt to reinforce the sick role or other dependency needs.

At the other extreme are advocates of the more or less standardized 28 to 30 day hospital (or hospital-like) programs, as well as longer programs such as therapeutic communities. Arguments for these programs include the need for more intensive therapy or rehabilitation, the need to recover more fully from the various toxic effects of addiction, and a need for temporary removal from habitual temptations of the environment.

In between these extremes are the largely medically-oriented programs that provide hospital detoxification, usually lasting 3 to 14 days, with immediate referral after medically supervised detoxification to various outpatient or halfway house services. Such programs emphasize the medical aspects of addiction, although there is almost always an attempt to begin dealing with the psychological, social and spiritual aspects as well.

Since all of the above approaches can claim their share of successful outcomes, it is impossible to choose among them if one's goal is to develop a uniform approach to treatment. A more sensible alternative, however, would be to change our emphasis from establishing fixed programs, in which we try to fit all types of addicted persons, to an emphasis on determining individual patient needs and thereby providing as individualized an approach as possible.

Within a hospital-based program, this latter approach can be achieved by dividing the program into distinct phases of treatment and by applying a method for designing an individualized service plan. The remainder of this paper will describe such a program.

FLEXIBLE THREE WEEK PROGRAM

Inpatient treatment is recognized as only the beginning of a much longer program for recovery. It is designed to average approximately three weeks in length, but allows for much shorter stays as well as longer stays. We have attempted to compensate for deficiencies in the longer-stay programs by legitimizing the short-stay patient, and also for deficiencies in the shorter-stay programs by providing the alternative of longer stays with intensive psychosocial treatment. This is accomplished by dividing the program into three distinct phases and, as will be described later, individualizing the treatment plan.

Phase 1—Assessment and Detoxification

The first phase involves individual assessment and medically supported detoxification. For most patients, this will require 3 to 7 days of treatment, but it may be longer in the cases of severe or prolonged addiction and in those with medical or major psychiatric complications. This phase includes detoxification, per se, in addition to a team evaluation of physical, psychological, social and vocational needs. The patient is oriented to the nature of addictive disorders and to possible treatment alternatives. Within 3 to 5 days of admission, a treatment plan is developed by an interdisciplinary treatment team, which is negotiated with the patient and, when possible, with other significant people such as the family, employer, or criminal justice agencies. Much of this planning may even take place prior to admission if time and circumstances allow it. At any rate, the

* Dr. Wieland's address is Ridgeview Institute, 3995 South Cobb Dr., Smyrna, Ga. 30080, where he is Director of Education and Training.

plan will either permit discharge shortly after detoxification or entry into Phase 2, depending upon the patient's resources, outside support, internal motivation, etc. In either event, since the plan is negotiated in explicit terms, it frees both the patient and the staff to work toward the agreed upon goals of the individual, instead of the goals of the program.

Phase 2—Intensive Treatment

For those who proceed to this phase, the emphasis is on intensive treatment of psychological, social (e.g., family, work, and leisure time activities and relationships), and spiritual needs. The duration is 7 to 10 days for most patients, although it can be longer for those with more serious psychiatric, medical or behavioral complications. This phase includes group therapy, individual therapy, family counseling, introduction to Alcoholics Anonymous, and educational sessions regarding the nature and management of addictive disorders. Therapeutic activities are provided and patients are specifically encouraged to expand their repertoire of non-drinking leisure time activities. Most patients who complete this phase will continue into Phase 3.

Phase 3—Continuing Care Planning

It is widely acknowledged that recovery from addictive disorders is a long-term—even a lifetime—process. Hence, sound planning for continuing care is essential. During Phase 3, the treatment team, again in negotiation with the patient and other significant persons, develops an explicit and individualized continuing care plan. This phase lasts about 7 days, but may be extended in the event of major complications with the family, employer, or criminal justice agencies. The intensive treatment modalities are maintained throughout Phase 3, but additional time is spent working out the details of continuing care. The alternatives include various combinations of the following: Alcoholics Anonymous, psychotherapy, chemotherapy, group or family therapy, employment counseling, halfway house, addiction clinics, medical care, and spiritual counseling. Whenever possible, all of the pertinent services are arranged, spelled out in writing, and signed by both the patient and staff. Input is also encouraged by other patients who have come to know some of the personal needs of their fellow patients.

It can be seen from the above description that both patients and staff are made aware of the treatment expectations of each phase and can shorten or lengthen each phase, depending upon individual progress. The prescribed treatment modalities can be as broad or limited as necessary to address specific medical, psychiatric, social, behavioral or spiritual disabilities. Our method for arriving at this individualized approach is summarized in the Individualized Service Plan.

INDIVIDUALIZED SERVICE PLAN

Figure 1 is the format for the Individualized Service Plan (ISP). At the top are entrees for the start date of the plan, the projected discharge date, and the first review date. Establishing these time frames at the outset is critical since people usually work more productively when there is a deadline for completing the task. This is equally true for both patients and staff.

The next two boxes provide space for a list of pertinent assets and pertinent problems of the patient. Treatment approaches and anticipated outcomes are greatly influenced by the balance between one's assets and problems; hence, it is useful to list them in a summary fashion, even though they may also be addressed in more detail in the narrative portions of the medical record. A key word is "pertinent," meaning that the lists should not be exhaustive or trivial in nature.

Having listed the pertinent assets and problems, one comes to the heart of the ISP, namely the specific goals toward which the patient and staff are working and the interventions chosen to achieve

Figure 1

RIDGEVIEW INSTITUTE
Individualized Service Plan

Start date: .... Projected discharge date: .... First review date: ....

Summary of pertinent assets (physical, psychological, social, educational)	Summary of pertinent problems (physical, psychological, social, educational)
1.	1.
Goals—anticipated outcomes (measurable and time-limited when possible)	**Intervention plan—methods and providers (specifically chosen to meet the goals)**
1.	1.

Treatment team members formulating plan:

....
Name Title Name Title

....
Name Title Name Title

Treatment plan coordinator: .....
Name Title

Attending physician: ....., M.D.
Name

If patient reviewed plan: .....
Signature of Patient

Comments or special considerations	Patient identification

these goals. Whenever possible, the goals should be stated in measurable and time-limited terms so that one knows for certain whether or not they have been achieved. Of equal importance, the interventions must be selected to specifically address the stated goals; e.g., a family problem would usually be better resolved by a family intervention than by group therapy, a legal problem might be better addressed by obtaining a lawyer than by individual psychotherapy, etc. Each intervention should list the provider, either an individual or a team, in order to provide accountability for delivering the specified service.

Following the goals and interventions are spaces for entering the names and titles of team members who formulated the ISP and for approval by the attending physician. Since we favor active input and negotiation with the patient, there is also a space for the patient's signature. Finally, there is space to list any further comments or special considerations, which are usually items of an urgent nature that all staff may need to know in a hurry. These might include suicidal or elopement risks, seizure precautions, disallowance of certain visitors, an upcoming court appearance, and so on.

Figure 2 is the format for plan review and modification. It is essentially identical to the ISP with an additional item at the top for commenting on the adequacy of documentation in the record and items at the bottom regarding initial discharge planning. The middle section summarizes the amount of progress toward goal achievement. Each plan must be reviewed at least once a week and documented on this format.

Figure 2

RIDGEVIEW INSTITUTE
Service Plan Review and Modification

Review date: .... Projected discharge date: .... Next review date: ....

At this time, is there adequate documentation in the record? Yes....

No ....

Additional assets	Additional problems
1.	1.

Progress summary for each goal and each intervention

1.	1.

Additional goals	Additional interventions
1.	1.

Team member(s) reviewing and modifying service plan:

....

Name Title Name Title

Plan Coordinator:

...., M.D.

Name Title Attending Physician

If patient reviewed plan: .....
Signature of patient

Plans for discharge and continuing care:

1. Practitioner or program(s) .....

2. Residence: .....

3. Employment: ..... 4. Other: .....

Comments or special consideration	Patient identification

CONCLUSION

By carefully defining the several phases of inpatient treatment and by preparing a detailed individualized service plan, it becomes possible to avoid the all-or-none thinking that so often characterizes this field. The length of stay will be determined more by the needs and the goals of the patient, rather than the needs and goals of the treatment program. Such patient-oriented needs and goals can be more adequately explained to insurance carriers, employers and families than the customary program-oriented goals could ever be. There is certainly no evidence that all addicted persons need only short-term medical detoxification, any more than there is evidence that they all need 28 days of prescribed treatment. Since both types of treatment can be offered in the same setting, the individualized and phased approach described herein offers a more reasonable alternative.

Additionally, this approach is ideally suited for conducting evaluative research studies in such areas as success or failure in achieving the stated goals and in long-term follow-up of patients with particular assets and problems, particular treatment interventions, particular lengths of stay, etc. Finally, it allows for the provision of different treatment approaches to those patients who relapse and are readmitted. When this occurs, both staff and patient have the opportunity to re-assess the patient's assets, problems and goals and, thereby, re-assess the interventions required to achieve recovery. It should be rare indeed that the second or third ISP will be identical to the first.

Our program is very new so that we cannot, at this time, report any results. It seems to be a reasonable approach to a complex problem, but only time and further experience will determine whether it is any more or less successful than many other approaches. We hope to be able to provide such documentation as data becomes available.



CREDITORS
MERCANTILE,
INC.

Doctors & Hospitals
Service Bureau

COLLECTION ACCOUNT CONTROL SYSTEM

Our Professional Collection System Insures:

- Easy Placement of Delinquent Accounts
- Prompt, Regular Follow-up
- Professional Telephone Contacts
- Approved Notices and Letters
- Bonded and Insured Protection
- High Recovery Ratios
- Maintenance of Customer Goodwill

We understand your credit
and collection problems.

Established 1914

Charter Member American
Collections Association
Member Associated Credit
Bureaus, Inc.



4 Executive Park Dr., NE, P.O. Box 95806, Atlanta, Ga. 30347 (404) 321-0999

"No physician should be too busy to concern himself with the whole story of health care and education's determining role in it"

The MAG and Education: An Update

STEPHEN L. DANIEL, Ph.D., *Atlanta**

Two years ago I reported in this *Journal* the activities and plans of the Medical Association of Georgia's new Division of Education.[1] Since then we have grown into one of the Association's busiest departments, nurtured by the unflagging generous work of the physicians on our large Education Committee.

Our efforts to date have taken two major directions: CME and health education. CME, or continuing medical education, conjures up pictures of hospital case conferences, specialty society meetings in Atlanta or Sea Island, and quiet evenings spent at home with medical journals. Health education is for the people who are the physician's family and neighbors and perhaps his patients. Both avenues of education are important to the MAG if it is to serve not only its own members but the healthy well-being of all of Georgia's citizens.

CME in Community Hospitals

MAG's Division of Education has been operating with the conviction that community hospitals are the best environment for CME. The reason is fairly obvious: there the physician can learn from his peers at minimal cost without taking large chunks of time from his practice. Our goal is to help every hospital in Georgia with over 100 beds develop an accredited CME program and to help all the smaller hospitals establish networks or consortia for the sharing of valuable CME resources.



MAG's Assistant Executive Director—Education, Stephen Daniel, Ph.D. (left) presents a Certificate of Accreditation to Lawrence Crimmins, M.D., Chief of Staff at Phoebe Putney Memorial Hospital, Albany. The accreditation is for the hospital's continuing physician education program.

So far the MAG has been directly involved in the accreditation of 11 hospitals. In addition, my travels have taken me to hospitals all over the state, where I have spoken to medical staffs about how to organize CME programs, how to get doctors to attend them, and how to apply for CME credits.

For the smaller hospitals, which do not have sufficient medical staff to justify regular scientific meetings, one answer to CME needs may be the hospital medical library. A group of such libraries in the same geographic area can pool resources (avoiding expensive duplication) and share the services of a "circuit rider" librarian specially trained to

* MAG Director of Education.

obtain the information which a busy physician needs to handle his more challenging cases. Start-up funds are available from the National Library of Medicine for this purpose, and we have been active in contacting hospitals and helping them to apply for these funds.[2] Other useful forms of CME for physicians in smaller communities are periodic visits from medical school specialists, video and audio cassettes, preparation for self-assessment exams such as the one given recently by the American College of Physicians, and home study courses.[3]

Medical Meetings

Every medical organization has a tradition of regular scientific meetings which give physicians a break from the routine of practice and an opportunity to hear the latest word from authorities in the field. Perhaps the biggest educational benefit of such meetings is the lively interchange of day-to-day experiences among the attendees who see each other principally at these meetings. The MAG is involved in medical meetings at three levels: it sponsors some of its own; it collects and provides information on others, and it assists in the accreditation of those deserving.

The MAG's biggest meeting is the Scientific Assembly, held every November in Atlanta. The 1976 Assembly attracted over 500 physicians. A good deal of effort and expense is devoted to this meeting, which is primarily a forum for concurrent scientific sessions planned by the specialty societies. The 1977 Assembly will feature an interdisciplinary workshop on asthma as well as sessions in sixteen specialties, with over 20 guest faculty. In 1978 the MAG and the Southern Medical Association will break new ground by holding a joint Scientific Assembly in Atlanta.

Each year the MAG also sponsors a MAGNET Conference designed to provide useful information on the socioeconomic side of medical practice to physicians, medical assistants and other physician advisors. Another very popular educational endeavor has been our sponsorship, with the AMA, of practice management workshops for physicians in the last stages of residency training who are preparing to set up their own practices.

Over the past two years the MAG has sponsored a one-day Institute on Decision-Making in Health Care, two weekend Legislative Seminars on government operations, a Conference on Medical Education, a Rural Health Conference, a Seminar on Emergency Medicine, and a combined Physician Recruitment Conference and Prepractice Seminar (for physicians planning to establish practice in smaller communities).

As a service to MAG members, the Education Division maintains a Medical Meeting Calendar with information about upcoming meetings of interest to physicians which will be held in Georgia and the Southeast. The information is gathered from a variety of sources and published monthly in our *Journal*.

"Many members pay lip service to education but are not to be found when it is time for action and leadership"

Specialty societies and medical organizations in Georgia seek to gain recognition of the quality of their professional education programs through a system of accreditation now administered by the national Liaison Committee on Continuing Medical Education. The MAG has assisted the national accrediting agency by conducting surveys of 14 such organizations. The surveys themselves are of educational value both to the MAG physician surveyors and to the educational leaders of the organization being surveyed, who pick up practical ideas about assessing the needs of their members, selecting relevant program topics and educational methods, and evaluating the success of programs in terms of stated educational objectives. During the past year, the MAG applied for and obtained accreditation for its own CME programs.

Health Education

Perhaps the most unexpected and promising development in the MAG's educational activities has been its growing involvement in the health education of the public. Although a number of MAG members undoubtedly spend time educating individual patients, few physicians have the time or teaching skills to provide formal health education to the laity. MAG's role in this area has become that of a coordinator and catalyst.

There is mounting evidence that all organizations concerned with health, including the State Department of Education and the Department of Human Resources, look to the MAG for leadership, support, and sound scientific advice in the health education which is provided, for the most part, by non-physicians. Underlying this expectation are several patent facts: doctors are respected for their scientific knowledge about health; they tend to wield a good deal of influence in their communities; they usually function as the decision-makers on the health care team, and they have no particular turf to guard other than the general health of everyone.

The MAG's Subcommittee on Health Education has delineated three areas of special concern: health education in the schools; patient education, and the use of the media for educating the public about health.

Our initial thrust has been with the schools, because we recognize that good health habits must be ingrained at an early age. Under the aegis of our subcommittee we have formed a coalition or "group" of persons responsible for the coordination of health education activities in the

schools. The group has met frequently over the past year and includes: physicians; leaders from the voluntary health organizations; health education coordinators for the Department of Education, local school districts and the Department of Human Resources, and professional educators of health teachers. We spend the first part of every meeting familiarizing ourselves with what we and our organizations are doing currently in health education. Here are some examples:

- The State PTA is using an audio-slide program, designed and presented by members of a special committee, to create awareness in parents and local school officials of the need for comprehensive health curricula in all of the public schools.
- The Georgia Heart Association and the Georgia Lung Association are working closely with several school systems in implementing the phases devoted to the circulatory and respiratory systems in a comprehensive health curriculum often referred to as the Berkeley Plan.[4]
- The Physical Health Division of the Georgia Department of Human Resources has instituted a variety of activities in health promotion, including district conferences, a health calendar, and immunization projects.
- The DHR's Mental Health Division is beginning this fall a program called Life Skills for Mental Health, designed to introduce teachers and other adults to the role they can play in helping students learn about themselves and what they want in relationships with others.
- The State Department of Education is now conducting pilot programs in nine of Georgia's ten congressional districts to assess the new state policy of competency-based education at the secondary school level. Included in the new curriculum is a unit of health, one of the life competencies which all high school graduates will be expected to possess.
- The Georgia Heart Association has been conducting an extensive HBP (high blood pressure) education program at the elementary school level. Although this is not a screening program, over 30,000 students have been taught how to take blood pressures as a way of involving them and their parents in the awareness of this disease. A related program is the Heart Association's Risk Factor Curriculum, piloted in ten schools last year during a two-week period.

The MAG's concern in these and similar projects is that the education be scientifically sound and that the agencies work together rather than at odds with each other. Only through the concerted efforts of a coalition of agencies, perhaps spearheaded by the MAG, can we hope to bring pressure on the state government and local school officials to legislate, fund, and implement effective health education programs in all of our schools.

"There is mounting evidence that all agencies concerned with health . . . look to the MAG for leadership, support, and sound scientific advice in health education"

Patient education is becoming a vital part of every hospital's services, and the MAG's Subcommittee on Health Education would like to take a more active role in coordinating and evaluating the work of patient educators. Our only activity to date has been our participation in an Atlanta-area consortium for patient education, which produced a useful resource guide. Our subcommittee would welcome the suggestions of anyone who has ideas about what works or might work in patient education.

Educating the public about health is a challenge which the MAG is just beginning to take up. We have in the past provided radio and TV stations with public service announcements, but now we are encouraging every county medical society to establish a committee whose principal concern is reaching the public. We are prepared to help such committees but recognize that the type of education must fit the community. A vigorous anti-smoking campaign, for instance, might not be well-received in a county where tobacco growing is a major industry. This issue of the *Journal* includes examples of community education projects sponsored by the Medical Association of Atlanta and the Cobb, DeKalb, and Dougherty county medical societies.

Conclusion

Education has arrived at the MAG. The physicians involved in our activities are enthusiastic and naturally feel that education should be ranked with legislation and peer review as a top MAG priority. If we have any frustration, it is that many members pay lip service to education but are not to be found when it is time for action and leadership. No physician should be too busy to concern himself with the whole story of health care and education's determining role in it. Our education committees—at the state, county, and hospital levels—need a steady transfusion of new blood to stay in touch with the problems and challenges of today. We will attempt to serve the educational needs of every MAG member. In return we ask every member to contribute what he or she can to our efforts to educate one another and our fellow citizens.

NOTES

1. Daniel, S. L.: "The MAG and Education," *JMAG* 64:375-77, 1975.
2. For further information, see Davies, N. E., "The Future of Small Hospital Libraries," *JMAG* 66:681-84, 1977.
3. An example of high-quality home study is the Family Medicine Refresher Course sponsored by the Georgia Academy of Family Physicians Educational Foundation. The course offers 100 hours of Category 1 CME credits.
4. See the article by Billy Gober, Ed.D., in this issue of the *Journal*.

The South's Most Complete BMW Dealer



CHRIS MOTORS

Whatever your BMW needs are, we can take care of them. We can sell you a BMW, or offer you a lease that includes a FREE LOAN CAR. We can take care of routine service, or handle any major repairs. We have our own body shop especially for BMW's. And we carry an excellent supply of BMW parts and accessories.

That's why Chris Motors is the South's most complete BMW dealer. Let us be yours.

1606 CHURCH STREET, DECATUR, GA.

PHONE (404) 292-1400 **NEAR NORTH DEKALB MALL**

How Does an Organization Obtain Category 1 Credits for Its CME Programs?

JAMES S. MAUGHON, M.D., *Atlanta**

PRIOR TO JULY 1, 1977, the American Medical Association had delegated to the Medical Association of Georgia the authority to conduct accreditation surveys to determine whether a hospital or medical organization in Georgia should be accredited for its continuing medical education programs. Since July 1, 1977, this authority has been transferred from the AMA to the Liaison Committee on Continuing Medical Education, of which the AMA is a member. At present, the LCCME continues to delegate to state medical societies (MAG included) the authority for survey, review, and development of recommendations on the accreditation of intra-state medical organizations and hospitals.

Pre-Survey Preparation

Since 1973, MAG's Education Committee has had an ongoing program of consultation and education by its physician members and Stephen L. Daniel, Ph.D. (Assistant Executive Director, Education), to encourage and assist hospitals and medical organizations in the awareness, need, and structure of CME programs over the state. Where interest is generated, MAG furnishes standards of quality to these potential providers of Category I accredited CME programs. The documents provided for information include:

MAG Standards for Continuing Medical Education

Guiding Principles for Continuing Medical Education

AMA's Booklet explaining the Physician's Recognition Award and criteria for the various categories of CME credit.

Hundreds of hours are being spent by physicians and MAG staff to provide accreditation to programs throughout the state

Application for Accreditation

The identified leaders who have the responsibility for organizing CME activities of the hospital or organization seeking accreditation should carefully review this material. If the overall CME programs meet these criteria, a request for an accreditation survey may be made by completing the Application for Accreditation and returning it to the MAG's Division of Education.

Survey

Members of the MAG Subcommittee on Accreditation will review the application, and if they agree that an accreditation survey is in order, a survey team will be selected for a site visit. The Sub-committee on Accreditation is composed of CME-interested physicians in the private practice of various specialties, CME deans of medical schools, and Directors of Medical Education of geographically representative hospitals of the state. Controversial applications are reviewed by additional members of the sub-committee for a consistent decision. Applications deemed not ready for survey are returned with a consultation list of major deficiencies, with encouragement for re-submission of a second application. In most cases, a second application with correction of deficiencies has been submitted. In the case of medical organizations other than hospitals, the site of the survey may be the MAG Headquarters building in Atlanta. A survey team consists of at least two physician members of the MAG (the chairman being the one who had had experience in previous surveys) and a MAG staff member who spends part of a day evaluating the applying institution's CME program. In addition to interviewing key members of the hospital staff or organization, particularly those involved in CME, the survey team may visit an actual CME activity in

* Director of Graduate and Continuing Medical Education, Georgia Baptist Medical Center and Chairman, Accreditation Subcommittee, Committee on Education, Medical Association of Georgia. Dr. Maughon's address is 300 Boulevard, N.E., Atlanta, Ga. 30312.

progress. Approximately 50 MAG physicians have served on survey teams to this point.

Post-Survey Process

Following the survey, the team will submit a report with recommendations regarding accreditation to MAG's quarterly meeting of the full Committee on Education. After discussion and evaluation, the full Committee will make a final recommendation about accreditation, and both the LCCME and organization will be notified immediately. After final review by the full LCCME, the state society is notified of the LCCME's final action. If the organization is approved for accreditation (thus far no MAG recommendation has been turned down), the LCCME will send a certificate of accreditation and MAG will arrange for its presentation. The duration of the accreditation will be specified, usually beginning with the date of the survey. The entire accreditation process ranges from 3-4 months, depending on the scheduled meetings of MAG and LCCME.

Hundreds of hours of time and expertise are being expended by interested physicians and MAG staff in this effort for the ultimate benefit of our sick and injured. Are you interested? Do you have alternate or better ideas? We welcome your participation at any level of our educational efforts!

Preparing an Education Program in a Community Hospital

JOHN A. HUDSON, M.D., *Carrollton**

THE RAPID EXPANSION of medical knowledge demands some form of continuing medical education. Governmental monitoring spurred by consumer advocacy requires it. Yet continuing medical education programs are impotent if they fail to reach the private practicing physician in the community hospital. These facilities and these individuals provide the majority of the primary medical care in this country. Currently, programs in these facilities fail to reach a large segment of the medical staff and also fail to change the bad habits of those who do attend. This is because they try to force-feed factual knowledge in a dull and inefficient manner. An educational experience designed for medical students will not correct deficiencies in the performance of experienced clinicians. These private clinicians have the greatest need to be current, yet no one encounters as many obstacles to attaining that goal. One may assume a basic motivation to learn, but must consider the limitations, especially of time. Efficiency is the key to a successful educational experience in this environment. The program must be related to patient care in an atmosphere of cooperation, friendliness, and mutual respect.

In planning a hospital education program, it is important to select subjects of importance to a large segment of the staff and to present knowledge that contributes to the quality of care

Several considerations guide topic selection. The program should be centered on a problem shared by as large a segment of the medical staff as possible. The problem should also be one of common practice experience rather than one of abstraction. Problem identification requires peer review. Physicians cannot be expected to sit down and objectively select topics that apply to their own deficiencies. Natural defense mechanisms hamper such a process. On the other hand, the audit techniques pushed by those who would organize medicine into a series of compulsory exercises which will magically improve quality of care are rejected by most private physicians. Also, the audit procedures established by national organizations generally have little relevance to the community hospital situation. They lack flexibility and mire busy people in a boring procedure. Experience shows that it is unrealistic to expect direct participation in peer review by a large segment of the medical staff, regardless of the technique. The immediate response of physicians who do not participate in development of criteria is to challenge the validity of those criteria. What we need here is a special technique that looks at a particular element of care selected for its importance to patient welfare and potential for improvement. Application of this will

* Internist at Tanner Memorial Hospital. Dr. Hudson's address is Tanner Memorial Hospital, Cardiopulmonary Clinic, 624 Dixie St., Carrollton, Ga. 30117.

fall to an interested group best composed of the thoughtfully selected Director of Medical Education along with the department chiefs. When they confirm the presence of a problem, you have the subject for a program.

Under no circumstances should the information gained in this quality of care assessment be used for punitive measures. Then you would have a source of division and deterioration rather than strength and education—a negative rather than positive attitude. Take your disciplinary considerations from another source entirely.

Consider program formats best able to fit the needs of the private clinician. The general staff medical-surgical grand rounds is a good example. Select a case that touches on the problem that has been identified. The attending physician presents the pertinent points of the case concisely and objectively with appropriate comments from radiology and pathology. A knowledgeable member of the staff or invited guest then addresses himself to the specific problem suggesting what he feels to be proper management. A question and answer period follows. Alert all discussants well in advance to greatly heighten the quality of the presentation.

The clinical-pathological conference (CPC) remains one of the most fascinating education experiences in medicine. Again, adequate preparation vitalizes the session. A clinical discussant with a flare for the dramatic adds another dimension. Distribute protocols early and be sure that the discussion is expert and particularly incisive with reference to your specific problem.

"Faulty thinking is more prevalent than lack of information"

Lectures are criticized as being too passive an experience for the audience. This format can only be salvaged by the force and personality of the speaker or by a topic so momentous as to be irresistible. Precede such endeavors with vigorous advertising. Don't pass up the opportunity to select a few patients for bedside teaching rounds by your visiting experts.

Supplement your programs with bibliographies of selected reading to be made readily available by your medical librarian.

The final step in the successful medical education program is the evaluation of its impact. This is best accomplished by repeating the process that identified the problem initially. Busy private practitioners reject the idea of pre- and post-testing. They also tend to fill out evaluation sheets distributed after a program in a hasty and impulsive manner.

Experience suggests that early-to-midmorning is the best time for conferences. That is, a time early enough to be the first order of the day for most, but not so early as to preclude a quick check of the critical patient. It is much more important to have enough prior planning to prevent wasting the staff's valuable time than it is to select an ideal hour.

Avoid certain pitfalls. Differentiate knowledge that increases our quality of care from fashionable belief. Don't concentrate on an unproven procedure in a misguided attempt to be timely. We must be especially cautious of canned presentations by outside agencies that might gain economically by establishing unsound beliefs.

Remember that the consensus of previous quality of care assessments indicates that faulty thinking is more prevalent than lack of information. Aim not to know more, but to think better.

Continuing Medical Education by TV Broadcasts and Videocassettes: The Emory Program

BERNARD L. HALLMAN, M.D., *Atlanta**

In 1972 we reported, in another journal,[1] the enormous growth made by the Georgia Regional Medical Television Network (GRMTN) since its beginning in 1967. Now, near the end of 1977, these figures seem small. The greatest growth has been in the use of programs on videocassettes. This has resulted in the entire United States being the "region" referred to in our name. This growth continues and, without effort on our part, is gradually becoming international.

The key to the success of GRMTN has been the circulating videotape library located and operated by the staff of the A. W. Calhoun Medical Library at Emory University School of Medicine in Atlanta. In our 1972 report the library had nearly 100 programs on tape. They were all recorded on the old

* Professor of Medicine and Associate Dean for Continuing Medical Education, Emory University School of Medicine, Atlanta, Ga. 30322.

style, one inch, reel-to-reel tapes in black and white. Today there are approximately 1100 tapes in the library representing 450 different programs, most of which are in color. All are on ¾″ videocassettes. A part-time librarian assistant mails out and receives around 800 tapes per month. These are sent in answer to requests from 114 members over the U.S. and to a few members in Canada and Mexico. Some tapes are also mailed from our dubbing center at Grady Hospital to other countries in Europe and Asia.

The obvious reason for such rapid growth was the great demand. Private companies were quickly formed all over the nation and, just as quickly, failed. The price would frequently be $350.00 for a thirty-minute tape that was copy-righted and could not be circulated or copied. We have reviewed many of these tapes and found them to be generally of inferior quality.

We have attempted to keep all of our prices as low as possible. It is possible for member hospitals to rent good programs for as little as 5 to 10 dollars each, depending on how many are ordered per year. Our programs are not copyrighted. We give all of our members written permission to show the tapes as often as they wish and to reproduce any of them for their own library. Several Area Health Education Centers order three or four tapes per month; a committee then picks out one that fits best into their teaching program. They will then make one or several copies to be circulated to their members, returning the originals to us.

In recent years there has developed an almost "mad scramble" on the part of some doctors to accumulate continuing medical education credits. This credit system was started by the American Academy of Family Physicians and has now been adopted by most specialty societies and some states. A count early in 1977 revealed that 14 state boards of medical examiners had issued regulations requiring CME credits for re-registration of the license to practice medicine. Five other states are working on similar requirements. Many of the specialty societies also require credits for continued memberships. So far all of these societies will accept the Physician's Recognition Award as at least part of these credits.

Are we really doing anything? Continuing education is so important for doctors and nurses that every effort should be made to make all CME courses effective. This is very difficult. A pre- and post-test for a thirty-minute discussion on TV would prove nothing. We could furnish a brochure on the subject with tests, etc., by putting two or three additional persons on our staff. This would price our tapes out of the market. Our programs have been selected for circulation only if the speaker is saying something useful, talking rather than reading, and if the slides are readable on a TV monitor. Popularity may not be the best method of evaluation, but when a tape has fifteen copies in the library and if these have been circulated since 1972, then we must conclude that the directors of medical education in many hospitals and medical schools think this tape is worthwhile.

The AMA has recently published a new booklet giving the 1977 instructions and information about the Physician's Recognition Award. There is a section on just how audio-visual material can be used for credit. The tapes we produce can always be used for credits under category 5 (self study). There is a limit of 22 credit hours that can be claimed. These credits are available to any doctor in the U.S. who can sit down and watch (and hopefully learn from) one of our tapes. Under formal circumstances, the tapes can be used for category 2 credits and even category 1 credits. These details are spelled out in the 1977 AMA publication *The Physician's Recognition Award*. No individual programs are approved by the AMA. Our tapes can be used only because Emory University School of Medicine is accredited for continuing medical education.

REFERENCE

1. Hallman, B. L.: Medical Television at Emory University School of Medicine. *Atlanta Medicine* 46:25-27, 1972.

MAG to Conduct Survey on CME

In early December the MAG will be conducting a survey to find out the practice and opinions of its members on a number of issues related to continuing medical education. Every member is urged to spend a few minutes completing the mailed questionnaire, since the validity of the survey will depend on the level of response.

The survey has been designed by MAG's Education Committee to assess MAG's involvement in CME, to determine the educational needs of the membership, and to generate data to be used in the discussions now beginning to take place about CME requirements for relicensure in Georgia.

Included in the survey will be questions on the relative value of various forms of CME, availability of CME at the local level, the benefit and cost-effectiveness of the Annual MAG Scientific Assembly and the pros and cons of CME requirements for licensure, recertification or membership in MAG.

Accredited CME in Georgia

A medical institution or organization may be accredited for its continuing medical education programs, provided it meets the standards for accreditation. Physicians attending programs sponsored or co-sponsored by accredited institutions may claim Category 1 credits, applicable to the AMA's Physician's Recognition Award.

Overall responsibility for accreditation rests with the Liaison Committee on Continuing Medical Education, a national accrediting agency with members representing the AMA, the Association of American Medical Colleges, the American Hospital Association, the American Board of Medical Specialties, the Association for Hospital Medical Education, the Council of Medical Specialty Societies, and the Federation of State Medical Boards.

The LCCME itself conducts accreditation surveys of medical schools and organizations whose CME participants come from three or more states. The Medical Association of Georgia has been delegated authority by the LCCME to conduct surveys of all other institutions and organizations in the state.

Following is a list of institutions and organizations in Georgia accredited for their CME programs:

Accredited Institution or Organization	*Director of CME or Contact*
American Academy of Pediatrics, Georgia Chapter	Alex F. Robertson, M.D.
American Cancer Society, Georgia Division	Shirley Preston
American College of Chest Physicians, Georgia Chapter	William Logan, M.D.
American College of Physicians—Georgia	Nicholas E. Davies, M.D.
Atlanta Graduate Medical Assembly	Wynnell Hopkins
Atlanta Society of Pathologists	David Stacy, M.D.
National Center for Disease Control (CDC)	W. N. Davey, M.D.
DeKalb General Hospital, Decatur	John A. Harrel Jr., M.D.
Emory University School of Medicine and affiliated hospitals	Bernard Hallman, M.D.
Georgia Academy of Family Physicians	Camille Day
GAFP Educational Foundation	Camille Day
Georgia Baptist Hospital, Atlanta	James S. Maughon, M.D.
Georgia Heart Association	Ann Angelo
Georgia Psychiatric Association	Harold L. McPheeters, M.D.
Georgia Radiological Society	Stewart R. Roberts Jr., M.D.
Georgia Society of Anesthesiologists	Z. W. Gramling, M.D.
Georgia Society of Ophthalmology	Talitha Russell
Georgia State Obstetrical and Gynecological Society	Chester Lane
Georgia Surgical Society	John P. Wilson, M.D.
Martin Army Hospital, Fort Benning	Cesar Lopez, M.D.
Medical Association of Georgia	Stephen L. Daniel, Ph.D.
The Medical Center, Columbus	C. Daniel Cabaniss, M.D.
Medical Center of Central Georgia, Macon	Bruce Schieneman, M.D.
Medical College of Georgia and affiliated hospitals	Glen Garrison, M.D.
Memorial Medical Center, Savannah	Carl Rosengart, M.D.
Northside Hospital, Atlanta	Barry Silverman, M.D.
Phoebe Putney Memorial Hospital, Albany	Thomas D. Johnson, M.D.
Piedmont Hospital, Atlanta	Mark Silverman, M.D.
Southeastern Angiographic Society	William Miller, M.D.
Tanner Memorial Hospital, Carrollton	T. M. Martin, M.D.
University Hospital, Augusta	Victor A. Moore, M.D.

Inquiries about accreditation should be addressed to Stephen L. Daniel, Ph.D., Director of Education, Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

Physician's Recognition Award Recipients

LISTED BELOW *are those physicians in Georgia who have earned the AMA's Physician's Recognition Award during 1977.*

The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or co-sponsored by organizations accredited for these activities.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Sidky A. Aboul-Khair, Augusta
Elliott Arthur Ackerman, Decatur
Rodolfo Ruben Agraz, Marietta
Earl Lewis Alderman, Atlanta
Andres S. Alisago, Fort Oglethorpe
Lawrence L. Allen, Thomaston
Henry Alperin, Augusta
John Carl Ammons, Decatur
William Lafayette Amos, Columbus
Daniel Jacob Appelrouth, Atlanta
George Foster Armstrong, Columbus
James Keyes Aton, Augusta
Bertram Price Avera, Dublin
Maryam B. A. Bahreini, Columbus
William Michael Bailey, Macon
Richard Alan Bardack, Marietta
William Roseboro Beach, Marietta
Jose Roberto Bejarano, Milledgeville
John Allen Bell, Dublin
William Howard Benson, Smyrna
Julian Berdusco, Augusta
Joel Edward Berenson, Atlanta
Morton Phillip Berenson, Columbus
Israel R. Berger, Athens
Robert Lowry Berry, Villa Rica
Dinker Bhole, Decatur
Joseph Arthur Bishop, Calhoun
Allan Bleich, Atlanta
Robert Martin Boger, Decatur
Neil Davis Boggess, Dalton
Charles Emory Bohler, Brooklet
Rodrigo Bonfante, Milledgeville
James David Bowen, Lakeland
Carl H. Brennan, Savannah
Elbert Harry Brown, Warner Robins
Carroll Daniel Cabaniss, Columbus
Orlando Cabrera Cicero, Dublin
Gordon C. Carson, Savannah
David Key Carter, Augusta
Sandy Baxter Carter, Atlanta
Robert Evan Chandlee, Marietta
Rodger William Chapman, Lilburn
Er-Wei Chen, Milledgeville
Kwong-Nan Chen, Dublin
Nicholas C. Chubb, Martinez
Joseph Citron, East Point
Roland Byrd Clark, St. Simons Island
Mark Gordon Coan, Atlanta
Fred Jessup Coleman, Dublin
Chappell A. Collins, Albany
Rudolf Albert Colmers, Savannah
David Lawrence Cooper, Forest Park
William W. Coppedge, Atlanta
G. Thomas Cowart, Atlanta
Charlotte Thames Cox, Macon
Carl LeRoy Crawford, Warner Robins
Hoyt Woodrow Crump, Clarkston
Leon Estese Curry, Metter
Benjamin Benitez DeGracia, Atlanta
Ervin Daniel DeLoach, Savannah
Richard Wallace Deatrick, Robins AFB
Henry Clark Deriso, Savannah
T. V. Hemalatha Devi, Augusta
Jagadishwar Devkota, Augusta
Richard Erwin Dixon, Atlanta
William Donald Dooley, Rome
Edward Farmer Downing, Savannah
Charles Anderson Duggan, Macon
John Gresham Durden, Columbus
Donald Milton Durrett, East Point
Henry Turner Edmondson, Augusta
Dan Berlin Elrod, Hazlehurst
Hossam E. Fadel, Augusta
Skina Hossam Fadel, Augusta
Samuel Edward Felt, Columbus
Bernardo Pedro Fernandez, Dublin
Eusebio Julio Fernandez, Ellijay
David Earl Field, Canton
Edmund M. Fitzgerald, Dublin
Francis W. Fitzhugh, Atlanta
Norberto A. Fontana, Thomasville
Edwin Reese Forsberg, Martinez
James C. Freeman, Sylvania
David Jay Frolich, Macon
William Henry Fulmer, Savannah
Henry Gall, Cairo
G. Garcia-Guerrero, Fort Benning
John Michael Garrett, Augusta
Francis M. Gay, Moultrie
Timothy Blaise Gibson, Winterville
Frederick E. Gilbert, Newnan
Robert Thornton Goetzinger, Marietta
Norman Isaac Goldman, Columbus
Gordon T. Goldstein, Atlanta
Francisco E. Gonzalez, Canton
Burton David Goodwin, Savannah

Ira J. Gordon, Dunwoody
Leo Gorelkin, Decatur
James Franklin Green, Villa Rica
Hubert T. Greenway, Marietta
Armando I. Gutierrez, Hardwick
Michael Allen Haberman, Atlanta
William Joseph Hamilton, Augusta
Taneemul Haque, Augusta
Sterling Adair Harris, Buford
Lewis B. Hasty, East Point
Rodney James Hawk, Columbus
Katrine Rawls Hawkins, Sylvania
Louis Abraham Hazouri, Columbus
Joseph A. Heffernan, Savannah
Charles Haddock Hendry, Marietta
Grady F. Herring, Fort Benning
Edwin Lee Hiatt, Valdosta
James Swann Hixon, Augusta
Lovic Worth Hobby, Atlanta
Jeff J. Holloman, Savannah
Wilmer Oscar Holloway, Tifton
A. Jean Edwards Holt, Augusta
George Richard Holt, Augusta
William C. Humphries, St. Simons Island
Jesse Lindsey Hunt, Brunswick
Richard Alva Hurd, Atlanta
John Thomas Hydrick, Roswell
William Oliver Inman, Brunswick
Ronald Isaacson, Savannah
Norman Frederick Jacobs, Decatur
William D. Jennings, Augusta
Salley Sue Jessee, Atlanta
Charles W. Johns, Macon
Walter Edwin Johnson, Augusta
George Randall Jones, Tucker
Henry Speir Jordan, Augusta
Joel Juarez, Stone Mountain
Guler L. Karcioglu, Decatur
R. Michael Kennerly, Augusta
Fred O. Kessler, Savannah
Horace A. W. Killam, Augusta
Tae Won Kim, Albany
Alan David Kirsh, Macon
Costas Kleanthous, Fort Benning
Gilbert South Klemann, Albany
Veeni Surender Kumar, Lithia Springs
Donald Mead Kurtz, Columbus
Robert Lee Kushner, Smyrna
Dixon Alexander Lackey, Atlanta
James Franklin Langford, Roswell
Willis Elliott Lanier, Atlanta
George Calvin Lawrence, Atlanta
Juan Fausto Leiva, Savannah
Alva Hamblin Letton, Atlanta
Michael Kalman Levine, Atlanta
Jack Heymann Levy, Augusta
John Grant Lewis, Rome
Mark M. Lindsey, Marietta
Kenneth Leslie Lipsitt, Atlanta
Juan Jose Llambes, Milledgeville
Michael Frederick Lubin, Atlanta
Wallace Lucas, Cochran
Ahmad Shafik Mahayni, Fitzgerald
Robert Mainor, Smyrna
Marvin Lee Marchman, Norcross
James Edward Marlow, Dalton
Alfonso Marmolejo, Atlanta
Herschel U. Martin, Dalton
W. Frank Matthews, Decatur
Stephen Cuthbert May, Kennesaw
John Henry Maylock, Augusta
Milton Mazo, Savannah
Martin Patterson McCann, Fort Benning
Dale Lynn McCord, Atlanta
Claude F. McCuiston, Chamblee
Donald C. McLean, Atlanta
Eugene C. McMillan, Macon
Eugene Neal McNatt, Columbus
Harold L. McPheeters, Atlanta
James Clayton Metts, Savannah
Cecil LeRoyce Miller, Buford
Chester O. Miller, Atlanta
Richard Nicholas Miller, Atlanta
William E. Mitchell, Atlanta
George E. Mixon, Dublin
Carlos Norberto Monarrez, Augusta
William L. Moore, Augusta
John G. Morrow, Monroe
Robert Nelson Murdock, Columbus
Dawson Leigh Murphy, Savannah
Byron Lamar Murray, Waynesboro
Ellyn Zunker Musser, Marietta
Mehmet Hikmet Nazli, Austell
Jocelyn I. Robb Neufeld, Athens
Edward Oliver Nix, Decatur
Feliciano Calma Nora, Rome
Zbigniew L. Olkowski, Atlanta
Horace Henry Osborne, Augusta
Clark Lamont Osteen, Savannah
James Edward Palen, Cairo
Frederick Langley Palmer, Smyrna
Havner Hurd Parish, Albany
Ashok Kumar R. Parmar, Warrenton
Keith Monroe Parmer, Canton
Josefina Parungao, Decatur
Alan Stephen Peiken, Columbus
Bobby Lamar Pilcher, Warner Robins
Geraldine Glover Pilcher, Augusta
Raul Jose Pineyro, Milledgeville
Glenn Sik-Hee Poon, Forsyth
Jose Maria Porquez, Monroe
Oscar Prada, Dublin
Edwin Noel Preston, Chamblee
Bill Purcell, Calhoun
Eyvin Paul Rasmussen, Atlanta
Edward Daniel Reisman, Rome
Walter Jones Revell, Louisville
Gary Oser Richman, Atlanta
Francisco Rivas, Augusta
David B. Roberts, Columbus
Clarence M. Rogers, Stone Mountain
Jim Lee Rogers, Rome
Orlando Otto Rojas, Atlanta
Richard M. Rosenberger, Acworth
David A. Russell, Atlanta
Floyd R. Sanders, Decatur
Lloyd B. Schnuck, Savannah
Paul Montford Sergent, Commerce
Issam John Shaker, Macon
Kailash Behari Sharma, Augusta
Rudy McKey Shirley, Dalton
Ivy Lee Shuman, Sylvania
Donald Carl Siegel, Atlanta
James Clarence Sikes, Macon
Stuart Eugene Sims, Atlanta
Richard Aurelius Smith, Atlanta
Richard Lyndon Smith, Cochran
Robley D. Smith, Tifton
William Sidney Smith, Atlanta
William Valdon Smith, Griffin
Jack Lee Sorg, Atlanta
Oliver Allen Sorsdahl, Atlanta
Minnie H. Lawrence Souma, Columbus
Simon Vasile Speriosu, Savannah
William Hugh Spruell, Decatur
Tommy Keegan Stapleton, Douglas
J. Benham Stewart, Macon
Carl Henry Strom, Chamblee
Robert F. Sullivan, Carnesville
Carroll E. Swanger, Rome
James Lee Tasse, Marietta
William Kevin Thomas, Atlanta
John Gill Thompson, Decatur
Robert Eugene Thompson, Toccoa
Rex Wallace Tidwell, Macon
Henry H. Tift, Macon
George Taylor Tindall, Atlanta
John Melvin Todd, Columbus
Robert McCormick Trent, Decatur
Corbett Harold Turner, Atlanta
Carroll Stewart Tuten, Brunswick
James Knox Van Buren, Atlanta
Jaydev Ranchhodji Varma, Augusta
Elmo Lavelle Walker, Cedartown
Robert Drane Waller, Albany
John A. Ward, Decatur
Richard S. Ward, Atlanta
Howell A. Wasden, Columbus
Donald Brent Waters, Blackshear
Francis M. Watson, Atlanta
James Quincy Whitaker, Warner Robins
Howard J. Williams, Macon
Joseph Post Williams, Athens
Nilda Beatriz Winiarski, Atlanta
Mohammad Zafiruddin, Louisville
O. Zapatero Gutierrez, Hardwick
Hugo Jacob Zee, Columbus
Robert James Zimmerman, Macon
Michael Zoller, Savannah
George Zubowicz, Columbus

Medical Meeting Calendar

DECEMBER

1-2—*Atlanta;* **CURRENT CONCEPTS IN THE DIAGNOSIS AND MANAGEMENT OF RETINAL DISEASES;** Category 1 Credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., Atlanta 30303, PH: 404/659-1676.

4-10—*Miami;* **AMA CONTINUING MEDICAL EDUCATION SEMINAR;** Category 1 Credit; Contact: AMA Department of Meeting Services, 535 N. Dearborn St., Chicago 60610.

6—*Fort Oglethorpe;* **DIABETES MELLITUS;** Category 1 Credit; Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe, PH: 404/866-2121.

8—*Augusta;* **ONE DAY ON DIABETES;** Category 1 Credit; Contact: Glen E. Garrison, M.D., Div. of Continuing Education, Medical College of Georgia, Augusta 30901.

8-11—*Atlanta;* **ASSOCIATION FOR ADVANCEMENT OF BEHAVIOR THERAPY ELEVENTH ANNUAL CONVENTION;** Category 1 Credit; Contact: G. Terence Wilson, Ph.D., Program Chairperson, AABT, 420 Lexington Ave., New York, NY 10017.

9-11—*St. Petersburg Beach;* **5TH ANNUAL SYMPOSIUM ON THE TREATMENT OF COMMON SEXUAL PROBLEMS;** Category 1 Credit; Contact: Bill Rockwood, Program Coordinator, Div. of Continuing Medical Education, University of Florida, Gainesville, FL 32601.

10-13—*Miami Beach;* **AMERICAN MEDICAL ASSOCIATION 31ST WINTER SCIENTIFIC MEETING;** Category 1 Credit; Contact: AMA Dept. of Meeting Services, 535 N. Dearborn St., Chicago 60610.

JANUARY

3—*Fort Oglethorpe;* **CARDIOLOGY;** Category 1 Credit; Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe, PH 404/866-2121.

11-13—*Louisville;* **MEDICAL ETHICS;** Category 1 Credit; Contact: Frank R. Lemon, M.D., University of Kentucky College of Medicine, Dept. of Continuing Education, Lexington 40506.

12-13—*Atlanta;* **REHABILITATION OF THE RENAL DISEASE PATIENT;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

13-17—*Key Biscayne;* **THIRD ANNUAL SEMINAR: PROBLEMS IN PEDIATRIC RADIOLOGY;** Category 1 Credit; Contact: Howard A. Wexler, M.D., Dept. of Radiology, University of Miami School of Medicine, P. O. Box 520875, Biscayne Annex, Miami 33152.

19-21—*Miami Beach;* **SYMPOSIUM ON AGING SKIN AND ITS CARE;** Category 1 Credit; Contact: AMA, Div. of Scientific Activities, 535 N. Dearborn St., Chicago 60610.

27-29—*Point Clear, AL;* **SOUTHERN RADIOLOGICAL CONFERENCE;** Category 1 Credit; Contact: J. W. Maxwell, M.D., Box 2144, Mobile, AL 36601.

31-Feb. 1—*Atlanta;* **PRACTICE MANAGEMENT WORKSHOP: ESTABLISHING YOURSELF IN MEDICAL PRACTICE;** Contact: Stephen L. Daniel, Ph.D., Medical Association of Georgia, 938 Peachtree St., N.E., Atlanta 30309, PH: 876-7535.

FEBRUARY

2-4—*Augusta;* **MAKING SURGICAL DECISIONS;** Category 1 Credit; Contact: Div. of Continuing Medical Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

3-5—*Chicago;* **AMA ANNUAL CONGRESS ON MEDICAL EDUCATION;** Category 1 credit; Contact: Paul Hagstrom, Meeting Management Dept., AMA, 535 N. Dearborn St., Chicago 60610.

6-10—*Atlanta;* **THE PHYSICIAN IN MANAGEMENT—SEMINAR II;** Category 1 Credit; Contact: The Physician in Management, 20 S. Quaker Lane, Alexandria, VA 22314.

7—*Fort Oglethorpe;* **PEDIATRICS;** Category 1 Credit; Contact: Mr. Stanley G. Hilliard, Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe, PH 404/866-2121.

8-9—*Atlanta;* **SECOND ANNUAL SYMPOSIUM ON PERINATAL DISEASE;** Category 1 Credit; Contact: Associate Dean for CME, Emory University School of Medicine, 69 Butler St., Atlanta 30303, PH 404/659-1676.

9-10—*Augusta;* **CLINICAL PSYCHIATRY;** Category 1 Credit; Contact: Div. of Continuing Medical Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

9-10—*Atlanta;* **MOBILITY ASSISTIVE DEVICES;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

9-11—*New Orleans;* **SOUTHEASTERN SURGICAL CONGRESS,** Category 1 Credit; Contact: A. H. Letton, M.D., 315 Boulevard, N. E., Suite 500, Atlanta 30312.

21-25—*New Orleans;* **AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION MEETING;** Category 1 Credit; Contact: Ms. M. S. Block, 1995 Broadway, 14th Floor, New York, NY 10023.

23-25—*Atlanta;* **AN UPDATE IN THE CURRENT CONCEPTS IN HAND MANAGEMENT;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Dir. of Continuing Education, Dept. of Rehabilitation Medicine, Emory University School of Medicine, Atlanta 30322.

24-25—*Durham, NC;* **FOURTEENTH ANNUAL E. C. HAMBLEN SYMPOSIUM IN PERINATAL MEDICINE;** Category 1 Credit; Contact: Carlyle Crenshaw, Jr., M.D., Box 3358, Duke University Medical Center, Durham 27710.

27-Mar. 1—*Augusta;* **PULMONARY DISEASES;** Category 1 Credit; Contact: Div. of Continuing Medical Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

The Case Against Mandatory CME

BENJAMIN B. WELLS, M.D., *Birmingham, Alabama**

MANY PUBLIC LEADERS, medical and nonmedical, are calling for a massive effort in continuing medical education in the expectation that the quality of patient care will be proportionately improved. As a means to this end, various threatening maneuvers are being made by professional organizations and governmental bodies which now seem to bring us to the brink of an era in which continuing education will be mandatory upon all who engage in the health care enterprise. Many seem ready to abandon the force of traditional professionalism, the fundamental ethic of quality performance, or trust in the individual warranty for service. Perhaps this is an inevitable development of our time, but we owe it to all concerned to examine with utmost care the rationale, the objectives and the methods of continuing medical education, before we impose this costly judgment on ourselves and our successors.

I hasten to emphasize what I hope may be obvious; namely, that I have a personal and deep concern for the development of effective programs in continuing medical education. I speak only to the question of compulsory or mandatory CME in whatever form it may take. That which is compelled by our own professional organization is, in my opinion, not substantially different from that which is mandated by state or federal government. Practically every "good" movement of our time has begun as a voluntary ideal, but it has ended in a set of regulations administered by a bureaucracy.

We tend to forget that the truly major determinants of health and longevity are of non-medical origin.

". . . almost any type of program extended to 4.5 million health care workers is certain to cost many millions of dollars. How is this to be paid and by whom?"

Scarcely anyone will doubt the importance to health of indoor plumbing, insecticides, practical housing and agricultural methods to furnish an adequate diet. At this point in our national history, general education and family income must have a higher priority for health than any element in what we call the health care delivery system.

If we look within the system itself for causes of substandard care, we encounter first the problem of no care at all. Many people who are sick or in danger of illness simply never see a physician. Potential patients often lack access to the system for geographic or financial causes, or they may just lack transportation. More frequently people do not know how to enter or to use the existing system.

Carelessness or indifference can be listed as a second major cause of substandard care. All health workers share the responsibility for a substantial number of patients who get into the system but who, for some reason or other, fail to be handled in a courteous and sensitive manner, especially in the critical initial phases of care. Human nature being as it is, we must work constantly to avoid indignities, delays, improper referrals and misunderstandings that can threaten the welfare and even the life of patients.

Communication problems loom large among the causes of substandard medical care. The nurse cannot read the doctor's orders; the pharmacist cannot read his prescription; a laboratory report fails to reach the patient's record in time; the patient or his relatives fail to understand the treatment regimen, so we have another case of "noncompliance."

Still another unfortunate defect is a kind of meddlesomeness. On this point, the doctor is most often at fault. The practice of so called "defensive medicine" tends to generate many examples. The patient is overinvestigated for fear of missing something. The use of "routine" or "battery" tests can also fall into this category. Invasive procedures should be avoided when noninvasive methods will serve the purpose. There should be no such thing as a "teaching procedure." Good teaching is a demonstration of the right thing to do, not an unstructured experiment.

At a higher level in the chain of events, the quality of medical practice can fall short because of an inadequate data base. Although physicians generally know what constitutes a proper patient record, our performances seldom reflect this degree of understanding. We often fail to ask the right questions, we fail to record some observations, we forget to list a test or procedure that we ourselves carry out. Not infrequently we simply fail to listen. A particularly troublesome defect in this category is a failure to record the fact that certain instructions and advices have been given to the patient. This creates a fertile area for malpractice litigation.

Sheer ignorance is probably the least common and the least important cause of poor medical practice. All the really consequential causes of substandard care, as listed above, are seldom, if ever, addressed in programs of continuing medical education. Believe me, this is not to suggest that we should be satisfied with

* Director of the Division of CME, University of Alabama, School of Medicine, Birmingham. This discussion was published in the *Journal of the Medical Association of the State of Alabama* 45: Vol. 45, No. 46, June 1976, and is reprinted here by permission.

the current state of knowledge in any group of health care providers. Quite to the contrary, our right to continue in the practice of medicine must be based upon evidence that all physicians are carrying on an adequate program of continuing education *on a voluntary basis*. My plea is for perspective on this topic. Continuing medical education in its current concept is not *the* answer, as many would have us believe, to all the problems that bedevil the health care field.

In formal programs of CME we find certain misleading implications that are subtle, never overtly expressed, nonetheless pervasive. First, there is the notion that the knowledge conveyed in courses is somehow certified as correct. Almost everyone who teaches must, in some part at least, cling to the fantasy that his material is a close approximation to eternal truth. Perhaps the charisma of good teaching begins with a degree of self-delusion. No one can be convincing until he has convinced himself. Alas, there is a day of reckoning. Biomedical knowledge is, at best, a transient probability. When education is mandated by the ambient society, it will be difficult to avoid the implication that we teach what is certainly true. Otherwise, how can we convince society to enforce the mandate and to defray the costs involved?

A related but somewhat more overt implication is that certain groups and individuals know how to practice medicine and their methods should be immediately transferred to the large body of physicians who do not know how to practice medicine. In some instances, this is interpreted as the "town-gown distinction." To my knowledge, there is no body of evidence to support this idea in this generation, but the implication is certain to produce antagonism if not downright hostility toward much of continuing education.

Do we know how to teach beyond the level of graduate medical education? The categorical answer is no, but by far the brightest spot in this entire field is the fact that valid experimentation is going on, and real progress is being made. Unfortunately, we have thus far found no way to demonstrate or measure improvements in the practice of medicine as a result of educational efforts. Moreover, we have yet to develop objective methods to determine educational needs among physicians and other health care workers. Hopefully, the process of patient care audit, as a part of PSRO, may yield new and useful insights into educational needs. For the time being, however, CME remains essentially experimental and pragmatic both in method and content. Again, this circumstance scarcely justifies a mandatory approach.

"The basic problem of CME is not the transference of scientific concepts but the alteration of human behavior. This is a challenge few of us have consciously faced."

All too many of those who advocate continuing medical education on a mandatory basis have not adjusted their perspective to existing reality. They visualize continuing education as a sea of expectant faces turned toward a podium from which a "topic expert" expounds the state of his art. Any experienced teacher knows that this format, in any one of several variations, will get you a large number of continuing education credits, but he also knows that as much as 90% of the information generated at the podium is falling soundlessly between the chairs of a nonparticipating audience.

There are others who think of continuing education in terms of hardware. They dote upon electrically operated motion picture screens, rear view projectors and public address systems that amplify the most timid voice but do almost nothing for ideas. More progressive schools are busily developing huge libraries and catalogs of "software" designed for the painless conveyance of knowledge and skills. Have we seriously asked ourselves to exactly what purpose is all this feverish activity directed? Are we getting any substantial part of what we pay for?

The need for continuing medical education is far less related to the emergence of new scientific knowledge or professional skills than it is to our failure to change old behavior patterns that are not suited to the requirements of modern health care delivery. The basic problem of CME, therefore, is not the transference of scientific concepts but the alteration of human behavior. This is a challenge that few of us have consciously faced in the past. I am confident that these difficult objectives can be met, but they will require time, ingenuity, and extensive revision in traditional methods of teaching.

Under the threat of mandatory CME, we have been overly concerned with the *process* of education. We are urged to register, to count the attendance, to measure the contact hours and to translate these into standard units. We are so busy keeping score that we may forget to play the game. *Our attention should be less on teaching and more on learning. We should look at the doughnut and not through the hole.* Learning is a private and highly individualistic matter into which teachers may seldom penetrate. Learning is an independent process which is subject to no external mandate. We may say that true learning begins with an individual desire, and individual insight into one's own needs, and individual resolution followed by self-discipline and self-responsibility. Teachers, if they are needed at all, only supply a measure of stimulus, select the pages and change the slides.

Many of us suspect, but do not know, that the behavioral patterns of health care are more likely to be influenced by reexposure of practicing physicians to the actual environ-

ment of teaching clinics and hospitals; essentially the environment of graduate medical education. Thus, we may be about to rediscover the wheel, and to suggest that physicians update themselves by a periodic return to the preceptorship, the internship or the residency experience. This approach, also, is fraught with many problems, but the problems can be solved if or when there is reasonable agreement to do so.

As CME moves toward a mandatory phase by requirement for membership in professional organizations, by recertification or by relicensure, at least two associated problems emerge. First, educational programs must be made available for the entire constellation of health care workers, and, second, some decision must be made as to who will bear the burden of the costs that will be generated.

No one can say at this time just what we may be facing in terms of total cost, but almost any type of program extended to 4.5 million health care workers is certain to cost many millions of dollars. How is this to be paid and by whom? So long as CME is on a voluntary basis, interested, ambitious workers will assume a large part of the expense themselves in return for personal satisfaction and opportunity for advancement. If CME is universally mandated, the cost will certainly be passed along to patients or to the taxpayers through government subsidy and management.

In either case, we have another substantial increase in the cost of medical care. As highly justified as this may be, we still must wonder what the traffic will bear. Surely no one will take a cavalier attitude toward a quantum jump in health care cost that would be precipitated by a decision to mandate CME for all workers.

And yet, it can be seriously argued that nothing less than the entire health care team must be involved if CME is to be truly effective. To say the very least of it, we should hope to have some answers to such questions as needs assessment, teaching methods and evaluation before commiting ourselves to so costly an undertaking.

A matter of prime concern to those of us who are engaged in actual production of CME programs is the potential impact of compulsion on the teaching and learning process. We must worry, first of all, that our existing resources will simply be overwhelmed. Thousands of reluctant students pouring in upon us at this time could dilute or even destroy our most valiant efforts. The expected result would become a feckless numbers game in which substandard courses would be contrived to fulfill the credit requirements. This turn of events would certainly lead to cynicism among students and would encourage all manner of evasive techniques to get the required credits at minimal effort.

"Practically every 'good' movement of our time has begun as a voluntary ideal, but it has ended in a set of regulations administered by a bureaucracy."

A not inconsiderable hazard will be the entrance of purely commercial interests to satisfy the market for continuing education units when the capacity of traditional, academic and professional associations has been exceeded. The large number and wide diversity of programs to create the demanded volume of educational units is certain to put an insuperable burden on accrediting agencies as well. This, too, will be a factor of cost to be somehow absorbed by a system already in financial distress.

Health care workers are responsible adults who deserve to be respected as such. For the most part, they have deliberately selected the health field, and they want to do their jobs well. If learning experiences are forced upon these people under threats to their dignity or even to their employment, the outcome is not likely to be an improvement in the quality of their performance. Our chief objective is to bring about a favorable change in behavior. Such a change must be totally accepted by the individual. Appropriate behavior must be willed and made an integral part of each worker's life. This type of goal is rarely fostered by compulsion.

It is now quite generally accepted that the right to practice medicine entails a moral commitment to a lifetime of learning. To fulfill this commitment, American medicine has been rapidly developing a vast network of programs for continuing medical education. The CME effort is still in a developmental and experimental phase. Although a great deal of progress has been made, many major problems are yet to be solved. How can the practicing physician take sufficient time for CME without seriously disrupting his service functions? How do we identify the faults of medical practice that are correctable by educational methods? How shall we pay the cost of CME extended to all members of the health care team?

These and other questions are being defined and partial solutions are beginning to emerge. Progress on a voluntary basis has been achieved in an orderly manner without overwhelming our capacity to create legitimate learning experiences, and, for the most part at least, without encouraging the development of substandard or spurious programs merely to satisfy arbitrary requirements.

If we are to retain the flexibility to experiment and to adapt both new methods and old ones to the solution of real problems, some of us are convinced that we must avoid all further moves toward mandated CME. There are good reasons to believe that the concept of lifetime learning will best survive and progress in the congenital atmosphere of volunteerism.

The Day the Doctor Brought a Cow To School

BILLY GOBER, Ed.D., *Decatur**

A heart-rending story about a far-from-ordinary school day . . .



Mark Silverman, M.D., cardiologist at Piedmont Hospital in Atlanta, dissects a cow heart at Bob Mathis Elementary School.

THERE WAS EXCITEMENT IN THE AIR; it was almost thick enough to cut with a knife. This was the day the children had been waiting for; the day the doctor was to bring a cow to school. They had learned about it in Phase I and talked all about it in Phase II and now they were almost through Phase III. It was time. Everyone in the school seemed to know something different was going to happen. The cafetorium, normally used for lunch, plays, and musical presentations, was being turned into a lab.

Finally, the teacher said the doctor had arrived and they moved single file into the cafetorium where the other fifth-year students had gathered. The media specialists had the TV camera and closed circuit video tape equipment there, and some of the other teachers were taking photographs. The teacher introduced Dr. Silverman, and he began to talk about the heart and how it functions, using terms the children had been taught during the last two weeks. He asked a lot of questions to see if the children really knew what he was talking about. They knew, but were impatient, wondering when they would get to dissect the cow's heart; after all, that's what they were here for and why the doctor had been invited. Finally, the doctor removed the cloth from a tray and revealed the largest heart one could imagine. After the doctor completed his dissection, exposing the valves and ligament that direct the blood flow through the heart, the children moved to the tables where they worked in small groups to dissect their very own cow's heart. The doctor came around and told them what an excellent job they were doing.

This story will be reenacted 20 or more times during the 1977-78 school year, thanks to the assistance of the DeKalb Medical Association and Dr. Alex Parkinson, who has agreed to serve as Health Education Chairman for the Association. He and Hank Holderfield, the Association's director, will see that community physicians get the opportunity to play a vital role in the health education going on in their neighborhood schools. All of this activity is part of the National School Health Education program commonly referred to as the Berkeley Project (because it originated in the Berkeley, California school district) housed at the Bureau of Health Education, CDC Headquarters, in Atlanta. This is an innovative health education program with units in the digestive, respiratory, circulatory, and nervous systems for grades four through seven. The program is an open education program in that it features hands-on activities. It is common to see five or more separate learning centers in a classroom at one time. Some children will be listening to audio tapes while they dismantle a plaster model of the human body; other children will be viewing slides, others looking into

Activities are designed to help the child understand himself and his feelings

* Coordinator, Health and Physical Education, DeKalb County Schools. For the last few years, Dr. Gober has taught a series of graduate courses entitled, "Health Education through Values Clarification." His address is DeKalb County Board of Education, 3770 North Decatur Rd., Decatur, Ga. 30032.



Students at Hendersonville Elementary School study health using an anatomical model.



Students at Hendersonville Elementary School, under the supervision of Billy E. Gober, Ed.D., use straws to inflate a cow's lung.

microscopes, and still others working with task sheets and diagrams of body parts and functions.

Such a program is in sharp contrast to the old textbook-oriented health that was taught on rainy days when the children could not go outside. The pilot program began in the summer of 1976 when two teams of teachers attended a model workshop taught in Atlanta. The school system purchased the supportive materials for the circulatory and respiratory units which were taught extensively in Henderson Mill and Bob Mathis schools. During the summer of 1977, these teachers trained twenty additional teams of teachers. During the present school year, the school system will test the feasibility of sharing this central set of materials on a system-wide schedule.

Transporting the materials boxed by phases from school to school is a major obstacle, as well as coordinating other resources such as acquiring beef hearts and lungs for dissection. Jack Mathis, of Mathis Dairy, came to the rescue by supplying the 5 or 6 hearts and lungs needed for each dissection session. Ms. Robin Hoffman, head of the Medical Lab Technicians program at DeKalb Tech, agreed to assist with the blood typing called for in Phase II of the circulatory unit. Thus, with parental permission, each child will understand why he/she has a particular blood type and the importance of that information.

A whole new approach to health education is being tried in DeKalb County schools

The National School Health Education program is part of a comprehensive health education program in the DeKalb school system. It lends itself nicely for inclusion into the curriculum as determined by the teachers themselves and printed in the system's curriculum guides.

The curriculum is divided into physical, mental and nutritional objectives with varying emphasis on each during the seven years of the program. In the primary years, mental health concepts receive the major thrusts with self-concept, communications and behavior as the topics for study. The mental health concepts are supported by accompanying physical health topics like body type, body language, physical feeling of stress, anger, happiness and the like. Nutritional education complements the curriculum at this phase by illustrating the social aspects of special meals on Sundays or on Thanksgiving as well as the nutritional value of food.

The DeKalb school district is utilizing a new program developed by the Department of Human Resources and State Department of

Education that complements the existing curriculum guides. This program is called "Life Skills for Mental Health." These activities are designed to help the child understand who he is and how his feelings about himself and others really shape his/her behavior. Smoke Rise School has also agreed to assist the Department of Human Resources with its media presentation which will present the program and its contents to educators across the state.

No stone is left unturned in an effort to offer a truly comprehensive health education program. Jackie Beard from the DeKalb County Health Department and Verna Barrett—a Vista volunteer—developed, in conjunction with school system personnel, activities that would complement the scheduled health screening in hearing and vision. These activities precede the actual health screening and help the children in first, third and fifth years (the vision and hearing screening years) to know more about sight and hearing. Plastic models were made and sent to each school to be used with the activities. Such an endeavor turns health service activities and health education information into a true health promotion effort.

The various health promotion agencies have excellent health education resources that need merely to be channeled into the scope of each school system curriculum. The Heart Association and its HBP program is an excellent example of hands-on activities where children learn not only the meaning of high blood pressure, but how to take it by using blood pressure cuffs and taking them home to read their parents' blood pressures. During the 1976-77 school year, this program was actually credited with saving a child's life who, unknown to herself and her family, had a seriously high blood pressure reading from a renal disorder. A kidney operation corrected the condition. The Council on the Prevention of Blindness, the Dental Auxiliary, the Cancer Society, and the Lung Association have curriculum and resource materials that can be channeled into a comprehensive health education curriculum.

The health education of the future will be taught by teachers who have been exposed to the full implications of humanistic education—teachers who have heightened sensitivity to the "teachable moments." When an illness occurs in the class, or someone cuts or scrapes a knee, the teacher conducts an impromptu lesson on the care of the body, the role of a doctor or nurse, the use and misuse of drugs, safety rules, concerns for others and so on. Nutrition education will broaden from information about the basic food groups to include the social aspects of food.

The ultimate objective of education—especially health education—is to assist the learners in making intelligent health-related decisions.

The School of Medicine at Morehouse College: A Progress Report

LOUIS W. SULLIVAN, M.D., *Atlanta**

The School of Medicine at Morehouse College hopes to become a "living laboratory" to prepare medical students for careers as primary care physicians in underserved areas.

On June 30, 1977, the School of Medicine at Morehouse College received a Letter of Reasonable Assurance of accreditation (LRA) from the Liaison Committee on Medical Education. Receipt of this document indicates that the medical school has formulated an appropriate development plan for medical education. The accrediting committee reviewed plans for financial support, faculty recruitment, curriculum planning, facilities planning, and administrative structures. The committee judged them to be sound and realistic, stating that they "may reasonably be expected to conform to the requirements for full accreditation within a reasonable time."

The receipt of the LRA is a significant milestone in our plan to admit the first class of 32 students in September, 1978. The School of Medicine is now preparing for a second site visit by the LCME in January, 1978, in response to our application for provisional accreditation. Once provisional accreditation is secured, the school will proceed with the admission of the first class.

The support which the School of Medicine at Morehouse College has received from the Medical Association of Georgia and the Georgia State Medical Association has been helpful in the school's development.

The need for the School of Medicine at Morehouse College was also endorsed by the Carnegie Council on Policy Studies in Higher Educa-

* Dean and director of the School of Medicine, Morehouse College, Atlanta, Ga. 30314.

tion in its 1976 report on medical and dental education in the United States. (Morehouse was the only developing medical school in the southeastern United States to receive such an endorsement.)

In addition, resolutions of support were voted by both houses of the Georgia Legislature. In the U.S. Senate Report accompanying the Health Professions Education Assistance Act of 1976 (PL94-484), the School of Medicine at Morehouse College was one of only two new medical schools in the U.S. which were cited as especially deserving of support by the new start-up authority in this Bill.

Letters of support have been received from local, state, and national governmental leaders.

Thus far, in 1977, the medical school has received a $1 million appropriation from the Georgia Legislature for fiscal 1978, a $1.2 million contract from the Health Resources Administration, DHEW, and a $320,000 medical school start-up grant from the Bureau of Health Manpower, DHEW. This evidence of broad public support is significant for continued development.

The school has developed a core of ten faculty and 13 administrative staff, and presently plans to add six more full-time faculty and five administrative staff prior to entry of the first class in September 1978. Part-time and volunteer clinical faculty are being recruited from around the state for teaching appointments.

Initially, the school will offer a two-year basic medical sciences curriculum. Following this, our students will transfer into the third-year class of four-year medical schools for their final years of study, through contractual affiliations with the Medical College of Georgia, Emory University School of Medicine, Howard University College of Medicine, and Meharry Medical College. Many other medical schools have also expressed a firm interest in affiliating with our program.

There will be 32 students in our charter class. The class size is planned to increase gradually to 96 students by the 1983-84 school year. According to present plans, the School of Medicine will develop into a four-year M.D.-degree-granting institution by 1983. The class that enters in 1983 is planned to continue for the third and fourth years of medical studies in the School of Medicine at Morehouse College, so that the first Doctor of Medicine degrees awarded by our institution will be in 1987. Prior to that time, the School of Medicine will apply for membership as an affiliated institution in the Atlanta University Center.

The first M.D. degree from Morehouse will be awarded in 1987

During its initial years, the medical school will be housed on the Morehouse College campus. By 1981-82, the medical school should be in its own physical facilities.

The basic sciences program has been developed by the Curriculum Committee, chaired by Dr. Stephen Margolis, Associate Dean for Academic Affairs. The curriculum will be primarily interdisciplinary with active use of problem-solving methods, audio-visual teaching programs, and computer-assisted instruction. The humanities and social sciences are also integrated into the curriculum, to preserve and enhance in our students an interest in careers as primary care practitioners for underserved rural and inner city areas.

The School of Medicine at Morehouse College has, as a part of its mission, the education and training of more Black and other minority physicians. We aspire to help provide the State of Georgia with those qualified medical practitioners who are committed to meet the health needs of our underserved communities. It is our plan that the School of Medicine at Morehouse College will become a "living laboratory" that will devise, implement and evaluate strategies to influence medical students to prepare for careers as primary care physicians in underserved areas. By placing a significant emphasis on the humanities and social sciences throughout the curriculum, we will increase the likelihood that our students will have a greater awareness of the personal and social factors which relate to the state of health or reaction to illness in their patients. We believe that it is important for medical students to understand the socioeconomic circumstances influencing those to whom they minister, in order to provide their patients with the most meaningful service.

Because there is a serious shortage of physicians in Georgia, especially for our poor and minority communities, we know that we will have the continued support of our efforts by all of our fellow citizens.

The importance of the School of Medicine at Morehouse College will transcend the number of physicians who will be graduated from it in future years. The presence of this medical school in the Atlanta University Center (the largest center of historically-black private higher educational institutions in the world) will assist all of the six affiliated institutions in their academic programs—by the development of new academic offerings, the provision of counseling services to pre-health professions students, enrichment of existing undergraduate and graduate curricula, augmentation of biomedical research efforts, and in other less tangible, but important, contributions to the academic milieu of the Center.

Because of the increasing prominence of the southeastern United States as a center of commerce, culture, education, transportation and service, and its increasingly international focus, we are confident that the School of Medicine at Morehouse College will significantly contribute to the development of Georgia and our region.

We look forward, with confidence and enthusiasm, to the years ahead.

Continuing Medical Education at MCG

GLEN E. GARRISON, M.D., *Augusta**

A PHYSICIAN TYPICALLY completes his residency training and begins his practice when he is approximately 32 years of age and then has a professional life expectancy of 30-40 years ahead of him. With the half-life of a physician's education at the end of his residency currently estimated to be approximately seven years, continuing education is essential throughout his entire professional career in order for him to renew his knowledge and keep abreast of new developments in medical care.

The three main ways that physicians continue to learn throughout their careers are 1) regularly reading journals and books, 2) informal discussions with their medical colleagues about problems that they encounter in their practices followed by selective reading and study on those topics, and 3) attendance at high quality continuing education programs.

The School of Medicine of the Medical College of Georgia has provided some continuing education for physicians for many years, but since 1970 the magnitude of the effort has steadily increased and diversified.

The current continuing education activities of our School of Medicine functionally can be divided into two types. The first type contains programs that originate primarily from within the Medical College of Georgia. These programs are announced by brochures and have advance registration. Some of these courses are designed to attract a large regional or national audience, and others are developed to provide individualized instruction to small numbers of physicians practicing in Georgia. Most of the larger courses last either two or three days, but some are considerably longer. Some of these programs are as narrowly specialized as a two-day program for clinical pathologists on a single laboratory test and a five-day program for cardiologists on the interface between current research in cardiac electrophysiology and patient care. Other programs are as broad as a five-day overview course for family physicians.

MCG offers 336 CME courses; during the past year, 8,850 individuals from 43 states participated in the program

The second type of continuing education contains those programs that are developed in response to requests from organizations outside the Medical College of Georgia. The requesting organizations are usually the medical staff of hospitals or medical societies in the various counties or districts in Georgia and neighboring states. Some of these programs are announced by brochures and have advance registration. The brochures are occasionally mailed to a wide geographic area, including national distribution for some programs. However, most of these programs are developed specifically for small local groups and often concentrate on topics that have been selected by the physicians who requested the programs.

One of the most unique aspects of the continuing education activities of our School of Medicine is those programs that are developed to help solve specific problems identified by practicing physicians relative to medical care in their own community. In some instances, we are asked to review specific operational problems in local hospitals and develop educational programs to help the medical and nursing staffs and also to help the hospital administration identify the various alternatives that could be used to improve those situations. Occasionally, very sensitive professional and/or political issues within the local hospital or community are factors in stimulating the local medical group to seek our consultation to identify appropriate alternative courses of action. In one instance, we were asked by the medical staff to develop educational programs relative to a serious unresolved conflict which had become sharply delineated between the medical staff and the governing board of that hospital. In these situations, the role of our program in continuing medical education is to arrange the appropriate consultative and educational services needed to help the local medical groups and hospitals formulate the various potential approaches to solving the problems that they have identified.

In those communities in which our institution is initially asked to provide consultative services on a particular problem, we often are subsequently asked to develop a series of educational programs based on other subjects of local interest. Separate programs for physicians and nurses are often developed in these educational series in order to

* Director, Program in Continuing Medical Education and Division of Continuing Education, Medical College of Georgia, Augusta, Ga. 30901.

give selective emphasis to the material that is of special interest to each of the two professional groups.

An individual who attends continuing education courses presented by the Medical College of Georgia may request a written record of his cumulative attendance at all programs from our Division of Continuing Education.

In summary, the School of Medicine of the Medical College of Georgia presented 296 continuing education programs in 42 different cities and towns in Georgia and neighboring states and in a still larger number of different institutions within these communities during the academic year 1976-1977. These programs were attended by 4,109 physicians, 1,550 nursing personnel, 348 allied health personnel, 18 dentists, and 1,624 other people for a total enrollment of 7,301. These enrollees in the courses presented by the School of Medicine comprised 82 percent of the total enrollment in continuing education programs at the entire Medical College of Georgia. The total enrollment in all 336 continuing education courses presented by the Medical College of Georgia during the year was 8,850. These individuals came from 43 different states with approximately 80 percent of the total enrollees being from Georgia and residing in 129 of its 159 counties.

Last year, 2,319 hours of instruction were given in the 336 courses presented by the Medical College of Georgia. This teaching was done by 440 different individuals with 300 of them being on the faculty or other professional staffs at the Medical College of Georgia. In addition, a total of 140 guest faculty members participated in providing the instruction.

The School of Medicine of the Medical College of Georgia is pleased to provide a wide spectrum of educational services to physicians and other health professional groups with primary emphasis on helping improve medical services throughout our state.

The School of Medicine at Mercer University: An Update

GEORGE R. BERNARD, Ph.D., *Macon**

Mercer will give preference to Georgia applicants and will emphasize family medicine and primary care

In the October 1975 issue of this *Journal,* there was a statement of "Status and Plans" for the developing School of Medicine at Mercer University. Among other things, it was reported that we had accumulated $10.6 million for capital development and were seeking funds from private and governmental sources for a stable base of operating monies.

Since then many things have happened which have changed the operational fund's picture. In fact, the school has developed a unique—and very broad—base of support. In August 1976, Macon voters passed a referendum for $7 million. Because this money can be used only for capital development, monies previously committed to capital development had to be shifted to the operation's side of the ledger. The Georgia General Assembly had, in 1973, appropriated $5 million for construction of a Clinical Teaching Facility. These state funds have been reappropriated to support the school's operation when federal funds are granted. Two million dollars donated mostly by Middle Georgians for a Basic Science Facility were also shifted. Several months ago, the medical school received a multi-million dollar endowment gift from the estate of Mrs. Mary J. Ray in honor of her son, Joseph Hamilton Ray. The first federal grant in support of this school was recently received under a program for new medical schools emphasizing family medicine. Once the Letter of Reasonable Assurance is received from the Liaison Committee on Medical Education of the AMA-AAMC, the school will be eligible for additional federal funds to support its educational activities.

The Medical School Library has grown to more than 10,000 volumes and will be the keystone in a twelve-member recently organized college and hospital library group, the Consortium of Health Science Libraries of Central Georgia.

Policies for admissions and curriculum are being worked out by faculty committees and the first class is now scheduled to be admitted in 1978 or early 1979.

Four policies adopted by the faculty and governing bodies which are of interest to Georgia physicians are:

(1) admission preference will be given to Georgians, especially applicants from rural communities;

(2) the undergraduate curriculum will emphasize family medicine and primary care;

The first class is now scheduled to be admitted in 1978 or early 1979

(3) the school will sponsor high-quality residency programs in primary care, programs big enough to absorb all the school's graduates; and,

(4) the faculty of this school are committed to offering continuing education opportunities to the health care professionals of this region.

* Dean of the School of Medicine, Mercer University, Macon, Ga. 31207.

Educating the Public about Health and Disease: The Atlanta Health Forums, 1977

NICHOLAS E. DAVIES, M.D., *Atlanta**

THE CITIZENS OF OUR COUNTRY are eager to learn more about health and diseases. Witness the many newspaper columns written by physicians, the many television shows about doctors and hospitals, the prominence of such people as Dr. Timothy Johnson of television and newspaper fame. Health education of the public is burgeoning.

It may be doing some good, although it is too early to be sure. There appears to be a lessening in the incidence of death from heart attacks and strokes. This decrease is temporally related to the Surgeon General's report of 1964 which stated that cigarette smoking is dangerous to the health of the smoker, and to the American Heart Association's efforts starting in the 1960's to lessen the amount of saturated fats and cholesterol in the American diet. It should be noted that there has not been as yet a reduction in lung cancer and chronic bronchitis.

The leaders of the Medical Association of Atlanta, after a hiatus of twenty years, resumed their program of health education of the public in January, 1977. They were motivated by a desire to improve local organized medicine's public image, a legitimate goal indeed. They joined with the two large Atlanta daily newspapers, *The Atlanta Constitution* and *The Atlanta Journal*, in producing four Health Forums.

The Forums consisted of four panels of experts, most of whom were physicians, who were chosen to represent a wide variety of health specialists, generalists, private practice and academia, races, geographic locations and other important variables. Each panel had four members and a moderator, the latter serving as master or mistress of ceremonies, fielding written questions from the audience and from questions sent to the newspapers. Each panel was convened on three successive nights at different locations in the metropolitan area. Topics chosen for discussion were: "Human Sexuality," "Tensions, Nerves and Tranquilizers (TNT)," "Foods, Fads and Fitness," and "Living with Pain."

"Citizens like to see their doctors contributing time and talent to the community . . . and to talk with their doctors when they're not sick"

The Forums were well publicized by the newspapers and were moderately well attended despite the very cold weather that necessitated postponement after the first panel was convened. The newspaper also sent reporters to cover the events, and their stories appeared almost daily, discussing the contents of the panel. These stories were read by thousands of people throughout the state.

It is impossible to measure all that was accomplished, but certain things were evident: there were many favorable comments to the panelists, the Medical Association, and the newspapers about the project; physicians in several other cities of the state are planning to produce similar programs; and the House of Delegates of the Medical Association of Georgia passed a resolution in 1977 encouraging all county medical societies to establish Health Education Committees. These committees, perhaps in conjunction with Public Relations Committees, might well produce similar programs for the public in the larger cities and in the medical society districts.

Our citizens like to hear about health and disease, but they also like to see their doctors contributing time and talent to the community outside their offices and hospitals. They like to talk with their doctors when they are not sick, when there is a person-to-person—not a doctor-to-patient—relationship, and when the atmosphere is less highly charged for them. These Forums gave a whole new dimension to physicians in general, as people who are interested in the health of the community. Many of us think this is important.

* Chairman of the Committee of Health Education, a sub-committee of the MAG Committee on Education. Dr. Davies' address is 35 Collier Rd. N.W., Atlanta, Ga. 30309.

Public Information Efforts

THE DOUGHERTY COUNTY MEDICAL SOCIETY has made several efforts to expand its informative contact with the public. An office with a part-time secretary and an answering service now provides daily service to those inquiring about medical care in Albany and surroundings. To bolster this effort, members were canvassed seeking the willingness to make appointments for persons having difficulty establishing contact for primary medical care. A small number of appointments are regularly made through the secretary. However, the emergency center with full-time physicians at Phoebe Putney Memorial Hospital remains the chief instrument for medical contact through which pa-

Cobb County Medical Society Symposium

". . . to establish better communication between professionals and the lay community . . ."



Charles R. Underwood, M.D. (left) and Noah D. Meadows, members of the Cobb County Medical Society, discuss their program with Margaret Mead, Ph.D., and Kennesaw College representative, Cullene Harper. Dr. Mead has appeared twice on the Cobb County Symposium.

NORMAN COUSINS, editor of *Saturday Review* magazine, and James A. Knight, M.D., dean of the School of Medicine at Texas A&M University, will be two of the featured speakers at the next annual Cobb County Medical Society symposium to be held April 6-7, 1978 at Kennesaw College. The topic for discussion will be "The Human Response to Change."

Past symposiums have featured such notable speakers as Dr. Margaret Mead, William Buckley Jr., Dr. Elizabeth Kubler-Ross, and former Secretary of State Dean Rusk. Topics discussed have included "America Vs. America—the Revolution in Values," "The Search for Relevance," "The Family in America," and "The Progress of Man Toward the Year 2,000."

The programs were started in 1965 by the Cobb County Medical Society to establish better communication between professionals and the lay community, and to encourage physicians to consider and treat their patients as whole persons.

Co-sponsors of the symposiums are the Woman's Auxiliary to the Cobb County Medical Society, the Cobb County Bar Association, the Cobb County Ministerial Association, the Cobb County Dental Society and Kennesaw College.

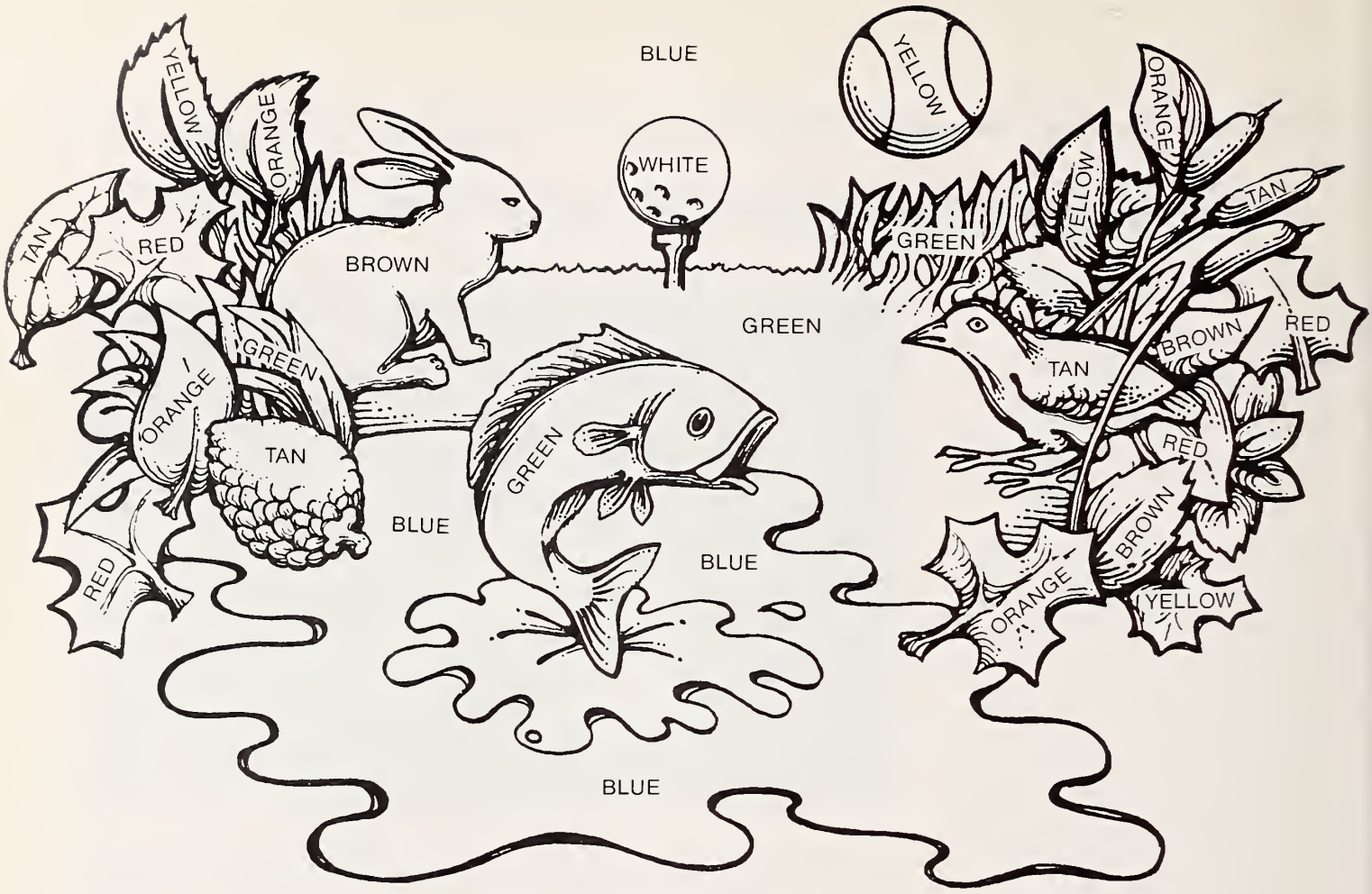
The symposiums are approved for credit by the American Academy of Family Physicians.

For more information, call or write the Cobb County Medical Society, P.O. Box 1208, Marietta, Ga. 30060, (404) 428-2812.

in Dougherty County

tients are referred. These referrals for follow-up care are made from the duty roster maintained in the emergency center.

A speakers' bureau was established providing a list of physicians willing to speak on a variety of subjects including headaches, lung diseases and smoking, topics in heart disease, hypertension, poisoning and common childhood ailments. The offer was sent to civic clubs and parent-teacher organizations detailing the plan. Individual contacts with physicians continue to be more commonly made for speaking engagements of this type, however. Press releases are prepared at intervals announcing scientific programs held by the society. These are provided by radio, television and newspaper outlets in Albany. Occasional paid newspaper advertisements have been placed, including announcements of our emphasis on hypertension case-finding and treatment in association with the effort of the Dougherty County units of the Georgia Heart Association this year. Medical grievances are also received through the County Society secretary.



LET US SHOW YOU LAKE ARROWHEAD'S COLORS THIS FALL

When we invite you to visit Lake Arrowhead in the Fall we almost feel like we're taking advantage of you. It's so hard to resist Lake Arrowhead's mountainside championship golf course when the leaves whisper so dryly around the bright green fairways. The cool, crisp air makes tennis on Lake Arrowhead's championship courts seem more invigorating than ever. The 500 acre Lake Arrowhead itself seems a deeper blue than even the cloudless sky. And at the end of a day the elegant dinner in the Country Club surpasses all your expectations.

Just thinking about Lake Arrowhead's comfort and beauty makes folks misty eyed. It's a life seemingly too good to be true but it's not...not by a long tee shot.

At Lake Arrowhead you can pick the homesite you've dreamed of, or build a home for now or later, or own a magnificent Mountain View Condominium Villa. All this just 56 miles north of Atlanta. What a place for you and yours to spend the rest of your life.

For complete information call 266-1002, visit our Atlanta office at 3400 Peachtree Road in the lobby of the Lenox Towers, or use this handy coupon.

Directions: From I-285 to U.S. 19 through Roswell to GA. 140. Once on GA. 140, follow the signs.

From I-75 go north to Roberts Road exit, then right to State Hwy. 5 to Canton, then north (left) on Hwy. 140 thru Waleska and follow the sign to Lake Arrowhead.

Lake Arrowhead is only 56 miles from Atlanta, 43 miles from Rome, 38 miles from Marietta, 21 miles from Cartersville, and 12 miles from Canton.



Yes, I am interested in learning more about Lake Arrowhead.

Name _____

Address _____

City _____ State _____ Zip _____

Telephone number _____

Mail coupon or write: **Lake Arrowhead**
Lenox Square Towers
3400 Peachtree Road, N.E.
Atlanta, Ga. 30326

Lake Arrowhead

Another Diamondhead Corporation Community

OBTAIN THE HUD PROPERTY REPORT FROM DEVELOPER AND READ IT BEFORE SIGNING ANYTHING. HUD NEITHER APPROVES THE MERITS OF THE OFFERING NOR THE VALUE, IF ANY, OF THE PROPERTY. THIS AD DOES NOT CONSTITUTE AN OFFER TO SELL IN ANY STATE WHERE SUCH AN OFFER IS PROHIBITED.

Tel-Med: A Progress Report

J. W. HOLDERFIELD, CAE, *Decatur**

In September 1974, Dr. Benjamin Okel, then president of the DeKalb Medical Society, and I authored an article entitled "Tel-Med—An Experiment in Patient Health Education" for the *Journal of the Medical Association of Georgia*. At that time we praised the overwhelming success of the program during its first three months of operation. We concluded by stating that "our brief experience indicates the Tel-Med concept to be a significant advance in patient health education and its vast potential to be limited only by available funding."

Now, three years later, it appears that we were prophetic in our concluding remark. Our call volume has decreased from a first year average of approximately 700 per day to approximately 175, primarily due to funding limitations. During the first two years, the C & S National Bank contributed almost $36,000 and the program thrived. Now the program is marginally financed through a small annual contribution from our Medical Society and the generous support of DeKalb General Hospital. Even the printing and distribution of brochures listing the tapes available in the Tel-Med Library is restricted by the lack of funds.

But a glimmer of hope surfaced recently and it now appears that rejuvenation of our sagging program has begun. Teletronix, the manufacturer of the sophisticated Tel-Med equipment, has decided to make our program its "showcase" for the Southeast and have allocated funds to that end. "Take one" placards were printed and distributed in our area for display of additional brochures. Recordings by such celebrities as Bing Crosby, Neil Diamond, Merle Haggard, Johnny Cash, and Julie London are now being played on Atlanta area radio stations publicizing Tel-Med, all prepared at the expense of Teletronix. TV coverage will again be attempted and the newspapers are to receive another barrage of press releases with photographs regarding the program.

"Patients want to know how to recognize early signs of illness and . . . how to remain healthy"

Also, discussions have begun with the Center for Disease Control in Atlanta concerning funding assistance. They were involved in the initial development of the national Tel-Med program and continue their interest, particularly with our Atlanta program. They realize the importance of patient health education in disease prevention and recognize the viability of Tel-Med as a health education modality.

For those unfamiliar with Tel-Med, it was conceived and developed by the San Bernardino County Medical Society in California in 1972 under funding from the California Regional Medical Program and the California Medical Association. It has now expanded into all areas of the country and continues to grow. Our program is housed in the PBX area of DeKalb General Hospital and is open from 12:00 noon to 8:00 p.m., Monday through Friday. Ten rotary lines are available to receive the calls. The caller requests a certain tape, either by number or subject title; the Tel-Med operator removes the tape from the handy storage module and inserts it in the special play back unit. At the conclusion of the tape, the cartridge is ejected and the telephone line disconnected, all automatically. Our Tel-Med Library consists of approximately 180 tapes, all carefully screened by a physicians' committee of the DeKalb Medical Society. Although the text of the scripts were written by physicians, professional narrators with the National Tel-Med Program in California prepare the tapes in their final form.

Even with the decline in call volume, the need for patient health information has been clearly demonstrated by the Tel-Med program. Patients want to know how to recognize early signs of illness and, increasingly, want to know how to remain healthy.

The medical profession must place a high priority on educating their patients and the community at large, especially in view of escalating health care costs. Nothing will impact the cost of health care more than an increased health-conscious lifestyle by the people. Patient health education programs such as Tel-Med are an excellent place to begin.

* Executive Director, DeKalb Medical Society, 755 Columbia Dr., Decatur, Ga. 30030.

Important.....

It may be a totally new experience for you or it may be the continuation of a secondary career.....

As a doctor in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found. . . . service to the community, state and nation.

In addition, many persons have found that the change of place and change of pace has resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for Georgia Army National Guard units. These "drill" periods, as we call them, can be very flexible to suit the needs and training requirements of the unit. Physicians even receive monetary support for attending CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS. If you need that CHANGE OF PLACE and CHANGE OF PACE, contact



Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662



editorials
editorials
editorials

Opsimathy and Other Responsibilities

YOUR MAG EDUCATION COMMITTEE, the largest and certainly one of the most active committees of our association, has a wide range of interests, as illustrated in this "Education Edition" of the *Journal*; interests ranging from our annual Scientific Assembly to public health education, to patient education, to liaison with our state medical schools, to a medical library program for hospitals, to accreditation of programs of continuing medical education, and to the cornerstone of our program, the improved availability of CME programs at the local level.

Our increasing awareness of relationships between lifestyle, disease and health emphasizes our responsibility for public health education and patient education. Medical societies are encouraged to establish active committees for public health education; hospital staffs are encouraged to establish active committees and departments for patient education.

Zealous pursuit by governmental agencies of documentation of evidence of continuing medical education has increased our responsibility to insure that opportunities are readily available. We know that physicians have always pursued their continuing education by a variety of means and have done so successfully. A lifetime of learning has long characterized the medical professional. However, the specter of relating certain evaluations of the currency of our medical knowledge to licensure for practice continues to hover over us.

Later this year, your Education Committee will conduct a membership-wide survey regarding your interest in continuing medical education. Your responses will be invaluable to us in our efforts to plan ahead. Your answers will also indicate how our association will spend some of your dues money. Please give us the benefit of a thoughtful reply to this survey.

Opsimathy, or learning at an advanced age, has always been a concern of our profession. However, at present, it seems to be in a renaissance.

LaMar S. McGinnis, M.D.
Chairman, Education Committee
Medical Association of Georgia

president's letter



Education: A Primary Goal

THIS ISSUE of your *Journal* is devoted to educational pursuits and activities of MAG. Continuing medical education has long been one of the primary goals of medical associations such as ours since their beginning. In fact, it was the quest for additional knowledge that led our predecessors to form the first informal associations which in turn led to the many formal organizations of medical professionals that we have today. So, continuing medical education is nothing new to our profession in spite of what many of our lay detractors would like to present to the public.

I do firmly believe that voluntary educational pursuits are far more effective than any compulsory programs which have been proposed by many who would entangle us in their red tape. Why do they not propose compulsory continuing education for other professions such as lawyers, architects, engineers, accountants—not to mention bureaucrats?

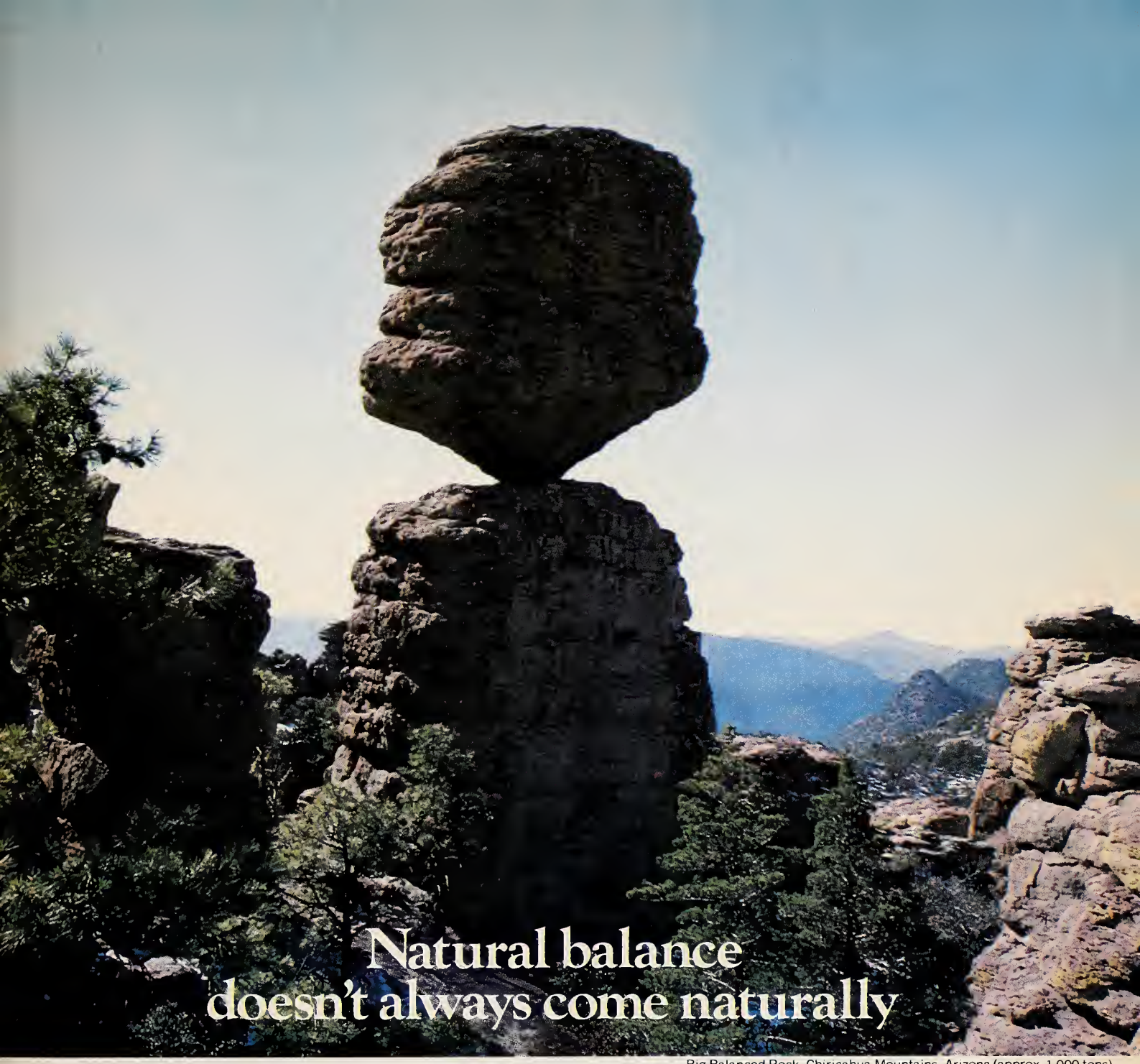
Your Education Committee, under the chairmanship of Dr. LaMar McGinnis Jr., is doing an excellent job for all of us in devising and bringing many opportunities for our benefit in improving our store of knowledge in our chosen fields. We all owe the members of this committee a large debt of gratitude for their efforts.

Last, but not least, I must tell all of you who did not or could not attend the recent MAGNET conference what an excellent program you missed. It was extremely well done and well worth the time spent. I strongly urge you to plan now to attend the 1978 conference. May I say thank you to Dr. Marvyn Cohen and the MAG staff for a job well done!

Sincerely,

Robert E. Perry Jr. M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

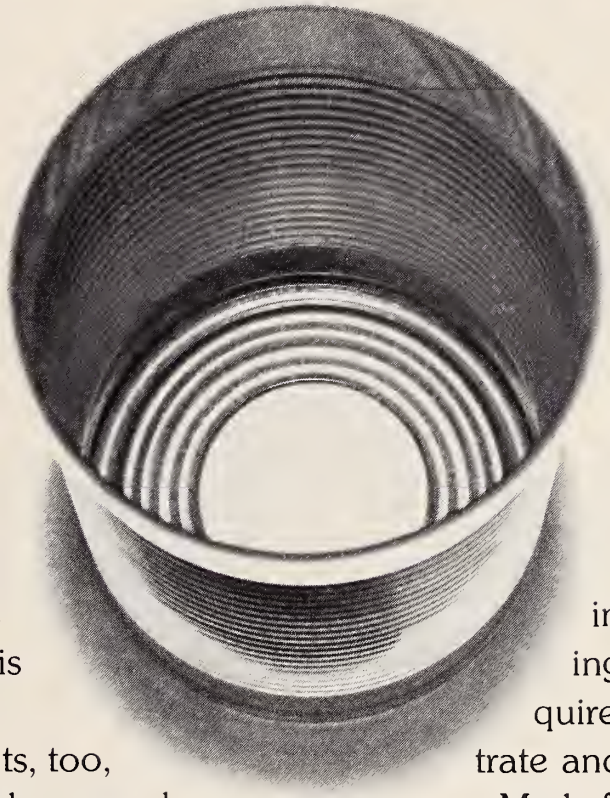
Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

NOW a two-piece 14oz. can for Soyalac



A two-piece can means no soldered seam. No solder means no possibility of lead contamination from the container. Soyalac is the first infant formula with this packaging innovation.

There are improvements, too, in the formulation. Soyalac now has 25% more iron than known competitive hypoallergenic milk-free formulae. In fact, the entire formula has been slightly modified to reflect the current U.S. RDA levels set by the Food and Drug Administration.

Soyalac—formula for infants on regular feeding and for those who require milk-free diets; concentrate and single strength, ready-to-use. Made from the whole soybean. I-Soyalac concentrate, made from soy isolate, with no soy carbohydrates and **no corn products.**



For detailed information and samples call or write:

Western U.S.
LOMA LINDA FOODS
11503 Pierce Street
Riverside, CA 92515
(714) 785-2444

Eastern U.S.
LOMA LINDA FOODS
13246 Wooster Road
Mount Vernon, OH 43050
(614) 397-7077

Loma Linda®

B.W.CO.® HAS PUT MORE POTENCY IN THE LINE



EMPRACET® with Codeine Phosphate, 60 mg, No. 4 Ⓒ III
EMPRACET® with Codeine Phosphate, 30 mg, No. 3 Ⓒ III

CONTRAINDICATIONS: Hypersensitivity to acetaminophen or codeine.
WARNINGS: Drug dependence. Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.
Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.
Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.
Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.
PRECAUTIONS: Head injury and increased intracranial pressure. Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.
Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.
Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.
ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.
DRUG INTERACTIONS: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Introducing EMPRACET® c̄ CODEINE #4

Each tablet contains: codeine phosphate, 60 mg (1 gr) (Warning—may be habit-forming); and acetaminophen, 300 mg. Ⓒ III

Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet c̄ Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet c̄ Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet c̄ Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® c̄ Codeine #3 provides effective relief of moderate pain.

Burroughs Wellcome Co. makes codeine combination products. You make the choice.

Wellcome | **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

I've told this before . . .

(Editor's Note: Listening in on your widow's thoughts may not be such a good idea, as shown in this story by Dr. Leigh. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Atlanta, Ga. 30309.)*

The Thoughts of Sweet Alice

I MUST SAY that this business of being dead has its interesting moments; I think you will agree with me when you hear my story.

I was in quite good health, and enjoying no small measure of success as a practicing physician in a medium-sized American town, when I suddenly began to tire quite easily and feel rundown in general. My wife and I attributed this to overwork, which certainly was a good possibility, so I slowed down my practice a bit. Even with the change, however, I continued to deteriorate and finally had to take to my bed.

My devoted colleagues who attended me in this final illness agreed that it was some form of liver degeneration, but they could not diagnose its cause. Despite their best efforts, and those of my courageous and devoted wife, I continued to go downhill and finally succumbed.

I had not been long in my new home up above when I happened on a physician who had practiced out in Indiana in the late 1800's. He confided in me that permission was sometimes granted for one to attend his own funeral down below, providing of course, he returned immediately after the proceedings.

"If you get close enough to people, you can hear their thoughts," he said. "I wouldn't advise you to go though; its just as well you don't hear what people have to say about you."

Notwithstanding his admonition, the prospects of such an adventure so intrigued me that I hastened off to the authorities and asked their permission; this was granted without delay, so I took off.

The chapel was never more beautiful nor the crowd so large. It was a scene to gladden the heart of any corpse. There were scores of my former patients and friends overflowing the room and spilling out into the hall. Floral arrangements were everywhere.

There on the front row, dressed in deep black, was Alice, my lovely wife, dry-eyed and courageous to the end, staunch in her sorrow. I looked at her long, wishing that I could speak to her, to tell her that I was all right.

Next to Alice sat Gregory, our best friend and companion of many adventures. He was a pathologist of some ability, and a confirmed bachelor if I ever saw one. I deeply appreciated his thoughtfulness in caring for Alice in these moments of heavy burden in spite of the sorrow that he too must feel in my passing.

I looked further: there in the fourth row sat Charlie, one of those who attended me in my final illness. I could not resist the temptation of hearing his thoughts, so I skimmed down close to him. ". . . temperature never spiked much, and his blood count wasn't up. It could have been a low grade infection, but I doubt it. He didn't develop jaundice until . . ." Good old Charlie, ever the clinician, still trying to diagnose my illness. ". . . Maybe we should have gone ahead with an autopsy, even though Alice didn't want one on her poor husband; it would have been nice to know . . ."

I darted here and there among my former patients and friends, feeling like an eavesdropper, but nevertheless enjoying the kind thoughts being expressed in my behalf. I wondered if any other doctor had ever had so gratifying an experience; I wished then that I had brought my new-found friend from Indiana along with me, to prove to him how wrong he was.

I was back to Alice and Gregory now—courageous Alice with face so firm, and Gregory with head bowed low in deep thought.

I was close to Gregory. ". . . I'm glad I didn't have to do an autopsy; thank heavens Charlie didn't insist . . ." Dear, kind Gregory, pathologist in a thousand such examinations, but still shy when it concerned his best friend. "I'm glad too for your sake, Gregory," I mused.

The service was almost over now. Like dessert after dinner, I had saved sweet Alice until last, saved her thoughts so that I could forever reflect on them in the leisure times ahead for me.

I came close to her, thrilled even now by her beauty and warmth. I listened. ". . . not sorry I did it. I'm not sorry I poisoned him . . . and now, before long, a wonderful life with Gregory. Gregory, Gregory, my love."

Ted F. Leigh, M.D.
Emory University Clinic
Atlanta, Ga. 30322

There is a better way to do it... You can find it!

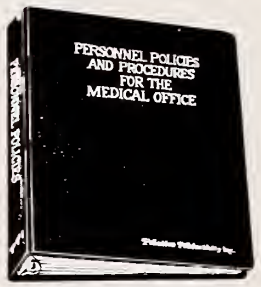
Two New Books Now Available -

PERSONNEL POLICIES AND PROCEDURES FOR THE MEDICAL OFFICE

Do you have personnel policies? Are they written? Are they up to date? Do they provide a clear, concise, competitive statement of what you offer and what you expect from your employees? Are your policies within the guidelines of recent legislation?

- Tells the employee what to expect on these important topics:

Working hours	Personal appearance	Vacation	Outside employment
Holidays	Personal phone calls	Housekeeping	Personal medical care
Smoking	Civic responsibilities	Parking	Compassionate leave



- Reviews policy topics for the manager in depth.
- Prewords sample policies for you on 23 topics.
- Makes you aware of many employer obligations such as:

Sick leave	Medical &	Salary	Summary dismissal
Personal days	dental appointments	Discipline	Other benefits
Probation	Performance review	Termination	Leave of absence

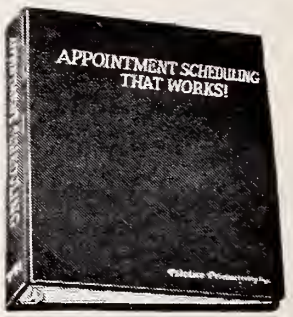
AN EASY WAY TO WRITE PERSONNEL POLICIES!

*

APPOINTMENT SCHEDULING THAT WORKS!

A course in appointment scheduling that enables your medical assistant to rebuild your scheduling system – according to the way you work.

- Your appointment employee learns about your real problems as she explores the improvements.
- The resulting schedule is custom designed for your specialty – the way you do things.
- Respects the patient's time. Keeps him from waiting more time than is reasonable - (usually 20 - 30 minutes maximum).
- Begin getting home on time.
- The workbook becomes a portfolio for continued improvement in future years.
- A simplified "Systems Analysis" approach to an age old problem.



A NEW APPOINTMENT SCHEDULE FOR YOU!

Practice Productivity Inc. **Management Consultants to Physicians**

Please send:

_____ copies of Personnel Policies and Procedures For the Medical Office at $24.50 + $1.80 for shipping and handling:Total $26.30.

_____ copies of Appointment Scheduling That Works! at $14.95 + $1.60 for shipping and handling: Total $16.55.

Send to:

Name _____ Telephone ( ) _____

Practice Name _____ Specialty _____

Address _____ No. of Doctors _____

City _____ State _____ Zip _____ No. of Employees _____

Bank Americard or Master Charge No. _____ Expiration Date ____/____Signature _____

Allow 2 - 3 weeks for delivery. Make check payable and send to:

PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30340 (404) 455-7344

Carcinoembryonic Antigen (CEA)

MARIO J. R. RAVRY, M.D., F.A.C.P., *Atlanta**

THE CARCINOEMBRYONIC ANTIGEN (CEA) was discovered by Gold and Freedman in 1965.[1] It is a glycoprotein with a molecular weight of 150-200,000, which migrates as a beta-globulin, and is found in the glycocalyx of human intestinal cells.[2] After its initial detection in human colonic adenocarcinoma and fetal gut tissue, CEA was detected and measured in serum using a radioimmunoassay method. The finding of positive results in 97% of colon cancer patients so tested raised hopes that this was an antigen specific for colon cancer and would enable the physician to detect colon cancer perhaps at an earlier stage. Subsequently, the CEA has been found to be neither specific for colon cancer, nor a screening test for the early diagnosis of any type of malignancy. CEA or CEA-like immunoreactivity has also been detected in urine, stool, and intestinal secretions of normal and of cancer patients.[2]

Techniques and Normal Values

There are various radioimmunoassay techniques available for the measurement of CEA, their respective normal values varying with the different laboratories. Correlations of 82-90% as to reliability and comparability among the various methodologies have been obtained during simultaneous testing of serum samples.[2]

Serum CEA levels do not vary with the age or sex of a patient, family history of cancer, or time of the day when the blood sample was drawn. However, CEA levels are higher in smokers than in non-smokers, and may be elevated in patients with various benign conditions such as cirrhosis, inflammatory bowel disease, pancreatitis, and chronic lung disease.[2] Usually, these levels are no higher than 10 ng/ml, and are transient in duration.

Commercially, the only assay approved for clinical use is the CEA-Roche test. Normal values for this assay are 2.5 ng/ml for non-smokers and 5.0 ng/ml for smokers.

---

* Chairman, Professional Education Committee, Atlanta City Unit, American Cancer Society. Dr. Ravry's address is Internal Medicine Group Atlanta, 607-A Doctors Building, 478 Peachtree Street, N.E., Atlanta, Ga. 30308. Prepared at the request of the American Cancer Society, Georgia Division. Others wishing to contribute papers to this department are invited to send them to David B. Roberts, M.D., 2400 13th St., Columbus, Ga. 31906.

Malignant Diseases

Serum CEA levels may be elevated in a variety of solid tumors, particularly cancer of the colon and rectum, pancreas, stomach, lungs, breast, and prostate. These levels vary with the stage or extent of a cancer, being frequently normal or only slightly elevated in patients with early and potentially resectable cancer, and markedly elevated in patients with widespread metastatic cancer. The fact that CEA levels are normal in a large number of patients with early cancer precludes its use as a screening test. However, CEA may be useful as an adjunct to established procedures for the diagnosis of suspected cancer, particularly intra-abdominal malignancies. Levels greater than 25 ng/ml are highly suggestive of advanced metastatic cancer, but a normal CEA level does not exclude the presence of cancer, either early or metastatic.

CEA in Cancer Therapy

Serial serum CEA measurements have been demonstrated to be useful for the follow-up of patients undergoing surgery, chemotherapy, or radiation for the treatment of cancer. Several investigators have demonstrated decreases in serum CEA levels following surgical resection, the drop in CEA levels correlating with the extent of resection.[3] Similarly, increases in CEA after tumor resection have been found to correlate with recurrence, frequently preceding clinical detection by weeks or months.[3]

Similar correlations have been observed in patients undergoing chemotherapy for advanced cancer of the gastrointestinal tract,[4] pancreas, breasts, ovary, lung, and other tumors.[2] However, CEA levels must be interpreted in the context of the clinical picture during chemotherapy since some patients who are pre-terminal may exhibit a dcerase in CEA levels even in the presence of advancing malignancy.[4]

Marker Panels

The possibility exists that the simultaneous measurement of serum CEA levels with those of other tumor-associated antigens and those of circulating enzymes, such as transaminases and alkaline phosphatase, may increase the physician's ability to detect advanced gastrointestinal cancer. When we measured CEA and alpha-fetoprotein simultaneously, 54% of the patients with gastric cancer had abnormal levels of one or both antigens.[5] Yet, only 22% of the patients had an elevated CEA level and 27% had an elevated alpha-fetoprotein level when either of these was measured alone. Similar complementary roles have been demonstrated for other circulating enzymes. Further studies are being conducted in this area by various investigators.

A More Specific CEA

Edgington and his associates recently isolated a fraction of CEA called CEA-S.[6] This assay has a very low incidence of false positive results in non-cancer patients, and detects a higher proportion of patients with gastrointestinal cancer than patients with non-gastrointestinal cancer. In spite of this, the test does not appear to be sufficiently sensitive to detect early and resectable gastrointestinal cancer.

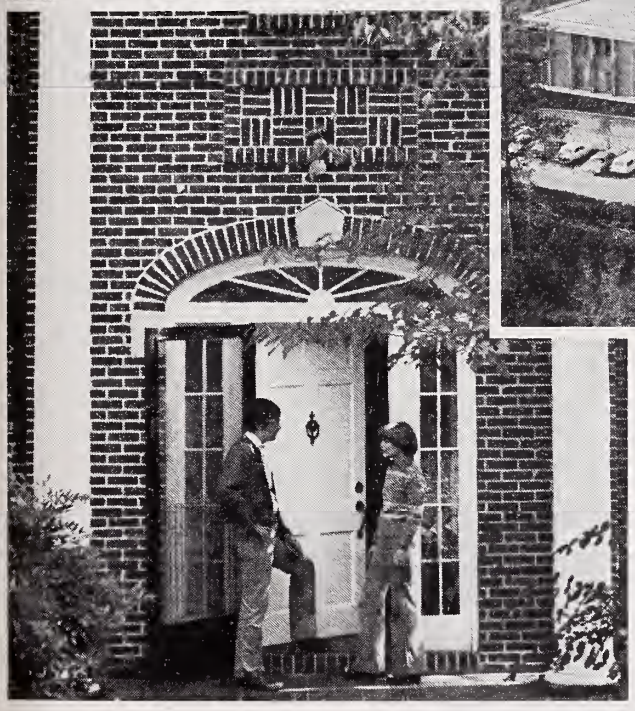
REFERENCES

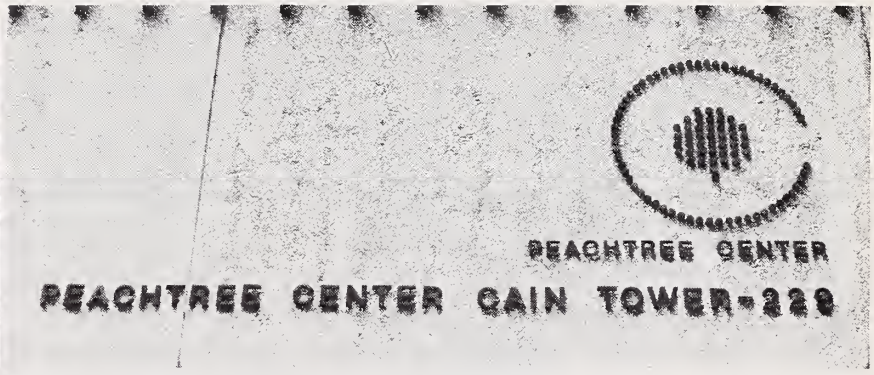
1. Gold, P. and Freedman, S. O.: Tests for Carcinoembryonic Antigen: Role in Diagnosis and Management of Cancer. *JAMA* 234:190-192, 1975.
2. Go, V. L. W.: Carcinoembryonic Antigen: Clinical Application. *Cancer* 37:562-566, 1976.
3. Heberman, R. B.: Immunologic Approaches to the Diagnosis of Cancer. *Cancer* 37:549-562, 1976.
4. Ravry, M., Moertel, C. G., Schutt, A. J. et al.: Usefulness of Serial Serum Carcinoembryonic Antigen (CEA) Determinations during Anticancer Therapy or Long Term Follow-up of Gastrointestinal Carcinoma. *Cancer* 34:1230-1234, 1974.
5. Ravry, M., McIntire, K. R., Moertel, C. G. et al.: Carcinoembryonic Antigen (CEA) and alpha-fetoprotein (aFP) in the Diagnosis of Gastric and Colonic Cancer: A Comparative Clinical Evaluation. *J. Natl. Cancer Instit.* 52:1019-1021, 1974.
6. Edgington, T. S., Astaritz, R. W. and Plow, E. F.: Association of an Isomeric Species of Carcinoembryonic Antigen (CEA-S) with Neoplasia of the Gastrointestinal Tract. *N. Engl. J. Med.* 293:103-106, 1975.











PEACHTREE & PARKWOOD SATELLITE SERVICES

In line with its philosophy of providing comprehensive mental health care for all of Metropolitan Atlanta, Peachtree and Parkwood has established four satellite services: one downtown at Peachtree Center, two at Duluth in Gwinnett County, and one on Briarcliff Road at University Drive. The satellites are:

- **Peachtree and Parkwood at Peachtree Center and at the Duluth professional Park**—both of these satellites offer individual, family and group psychotherapy and marriage counseling, psychiatric evaluation, psychological and vocational testing, and comprehensive alcohol and drug abuse services.
- **Parkwood House**—a supervised, adult, coeducational, non-profit halfway house which serves both as a bridge from the hospital to the community and as an alternative to hospitalization.
- **Parkwood Farm**—a specialized day treatment facility in Duluth which is for patients who don't require 24-hour care but do need more than out-patient office visits. The program, which includes group experiences as well as recreational activities, is designed to fit the individual need of each patient.

For complete information about these satellite services, contact:

PEACHTREE AND PARKWOOD

Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

Accredited by the Joint Commission on Accreditation of Hospitals

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard
OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

INTERNIST/FAMILY PRACTITIONER: TIRED OF CITY TURMOIL?

Lake Elsinore, which is located only one hour south of Los Angeles and one hour north of San Diego needs you now. The area offers the best of living conditions in one of the most beautiful areas of California.

Due to population growth, we are now in need of two Internists and one Family Practice Physician. We offer excellent guaranteed income for first year with free office space and household move provided. If you want a busy practice away from city pressures, write with C.V. or call:

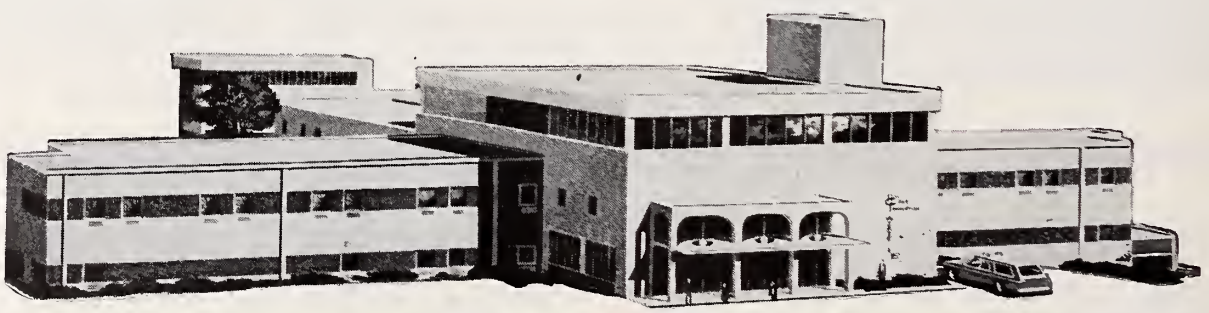
LAKEVIEW GENERAL HOSPITAL
Chris DiCicco, Administrator
P.O. Box 489
Lake Elsinore, California 92330
Telephone: (714) 674-1421

Hill Crest
HOSPITAL

Hill Crest Foundation, Inc.

A non-governmental psychiatric hospital. Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved.

Phone: 205-836-7201



A short-term, intensive treatment center for psychiatric disorders, alcoholism, and drug abuse.

Member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Birmingham Regional Hospital Council.

6869 Fifth Avenue South
Birmingham, Alabama 35212

Current Indications for Coronary Artery Angiography and Bypass Surgery—Part 1

GORDON C. MILLER, M.D., *Columbus**

EDITORIAL NOTE: The question that presented itself to Julius Caesar at The Rubicon confronts us daily as "to do" or "not to do" angiography and/or coronary artery surgery on patients with chest pain syndromes. Dr. Miller has very carefully described a general outline that will help in the decision.

Angina pectoris has been present since antiquity, although it was not classically described until the eighteenth century by Heberden. However, only in the last two decades has coronary angiography been refined and applied to give a unique understanding of patients, not available to our forebearers.

Hopefully, careful reading of the following article will help us all in managing our patients.—**Robert M. Patton, M.D.**

A REVIEW OF CURRENT INDICATIONS for coronary angiography and bypass surgery is presented as a "view from the field." Its sources are a careful review of the literature as far back as Block 1952[1] and as late as September 1977, our local and personal experiences, and some case management overlap with neighboring centers.

Prospective coronary artery disease patients are considered as they present clinically, and subgrouped.

Diagnostic Problems

The first subgroup would be those who present as diagnostic problems. There are several different presentations here. We have seen men and women, who have been admitted repeatedly with severe chest pain. Their most careful and experienced physicians have been afraid not to admit them, but on angiography they have been found to have normal coronary arteries, with good prognoses.[2] Their incidence has been reported as high as 37% of those with the *angina syndrome*[3] and they are most often significantly benefited by a definitive diagnosis.

Another subgroup are those with a *new onset* of symptoms strongly suggestive of myocardial ischemia or angina. The indication for coronary angiography here depends on the need for a definitive diagnosis in the individual case, e.g., the young fellow 35 years old who requests to know because he likes to participate in vigorous sports or must do heavy labor, or the airline pilot.[4] On the other hand, the elderly fellow with recent onset angina that has subsided, may not likely require angiography.

The survivor of an unheralded *cardiac arrest,* however, has been recommended for angiography because of the likelihood of a recurrence.[5]

It is understood in all these situations that careful historical, physical, and

* Dr. Miller's address is 2300 Manchester Expressway, Columbus, Ga. 31904. Articles for this page are prepared at the request of the Committee on Physician Education of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

clinical knowledge has been applied to exclude such obvious causes as esophagospasm, Tietze's syndrome, pericarditis, pancreatitis, etc.

Chronic Angina

Even in this group of angina patients we see subgroups. Those with *chronic occasional mild angina* do not need angiography or bypass. Those with *chronic, more severe but reasonably tolerable, angina* at this time do not need angiography or bypass. Those with incapacitating angina, if presenting or referred *untreated,* should first have a watchful trial of medical therapy. Those with *chronic severe angina refractory* to full medical therapy should have angiography and bypass if their ventricles and distal vessels are preserved sufficiently. See exemplary case. The surgical disposition of this latter subgroup is agreed upon almost universally,[6, 7] as a definite reduction in angina is obtained in 56 to 87%.[8, 9] The possibility of an eventual waning of this period of symptom remission has been described, however.[10]

After having outlined the above dispositions briefly for clarity, one must quickly add some qualifications.

Some would use angiography and bypass more liberally. This school describes an improved survival with bypass in the Cleveland Clinic experience 1967 to 1975 and other series, as compared retrospectively to the non-surgical group followed there between 1960-65. At years, the overall mortality, irrespective of the number of vessels, was 44% (8.8%/yr.) for non-surgical management, and 16.5% (3.3%/yr.) for surgical. At 5 years, one-vessel disease for non-surgical treatment was 16% (3.4%/yr.) and surgical, 12% (2.4%). If this one vessel were the left anterior descending, the figures were non-surgical, 24% (4.8%/yr.) and surgical, 8.5% (1.7%/yr.). At 5 years, two-vessel disease treated non-surgically was 49% (9.8%/yr.), compared to the surgical of 23% (4.6%/yr.). At 3 years follow-up, three-vessel disease non-surgically was 58% (19.3%/yr.) and surgical, 14% (4.6%/yr.).[8]

A recent randomized trial, however, showed no difference in mortality between medically and surgically treated groups. At three years, the mortalities were 13 and 12% respectively, 4%/yr. Another randomized series, followed two years, also showed similar survival. But here again there was a higher rate of symptom improvement with surgery, 89%. There was noteworthy 65% symptom improvement with medical therapy, however.[9]

It is then interesting to consider the Framingham 5-year attrition of angina cases, 18.5% (3.7%/yr.),[12] as well as that of the general U.S. population in the 5th decade at 5 years, 3.7% (0.74%/yr.), and at the 6th decade, 8.5% (1.7%/yr.)[13]

It has been found that angiographic signs are a better index of prognosis than symptoms.[14] In some of the cases angiogrammed because of intractable or unstable angina and then not operated on because of anatomic findings or a change in patient's desires, the knowledge of their ventricular and coronary anatomy and estimated prognosis by analogy has made the physician feel much aided in their overall medical management. This opinion is qualified as personal, but is not unique to parlance. In some cases, the symptom threshold may be high and not a true index of the severity of myocardial ischemia. Additional clues to an unfavorable prognosis and prompting earlier angiography are the abnormal resting EKG's[14, 15] and a treadmill ST segment depression over 22mm or a hypotensive response. These latter two signs suggest severe three-vessel disease or left main coronary artery stenosis.[16] Left main coronary artery stenosis jeopardizes the circulation of the entire left ventricle with a first-year mortality of 30% and 5-year mortality of 57 to 100%.[14, 17] Most series have shown a clear advantage to surgical treatment and a recent 30-month follow-up of 113 cases followed simultaneously, but not randomized, demonstrated a mortality in the medical group of 36%, and of surgery, 20%, 8%/yr.[18] The possibility of a similar

precarious prognosis has been raised by the "left main equivalent stenosis"; severe narrowing of a single vessel other than the left main could jeopardize a major segment of the left ventricular.[7] In my experience, their survival has been very brief, surgery precluded for other reasons.

Low yearly attrition rates have been reported for single right coronary artery stenoses (0.4%), and left anterior descending (2.6%).[14] Retrospectively, the Cleveland experience suggested an advantage in survival with bypassing the single left anterior descending lesion (annual attrition medically, 4.8%, and surgically, 1.7% per year).[8] A randomized series, however, of 53 cases at 24 months demonstrated no advantage in survival. Angina was abated in 25% of those treated medically, compared to 41% bypassed.[19]

The left ventricle in some patients is found, at angiography, amazingly well-preserved despite severe three-vessel stenoses, while in others, it is dilated and weakly contractile with only one- or two-vessel disease. The left ventricular integrity is critical in predicting surgical risk, however. A systolic ejection fraction below 30% (of the diastolic volume) suggests a high surgical risk and inoperability to most.[20] Recently, operative risks as low as 3% have been reported in patients with low ejection fractions by the liberal use of the intro-aortic counterpulsation balloon.[21]

As we proceed to weigh the risks for our patient, we must also consider the risks of angiography and surgery. Around the country, mortality for coronary angiography is 0.1 to 2.2%.[22, 23] Surgical bypass for lower risk cases are several percent and, overall, 5%.[8, 11] Here in Columbus, our figures are comparable and in the lower range.[24]—**Medical Treatment and Summary in Part 2, next month.**

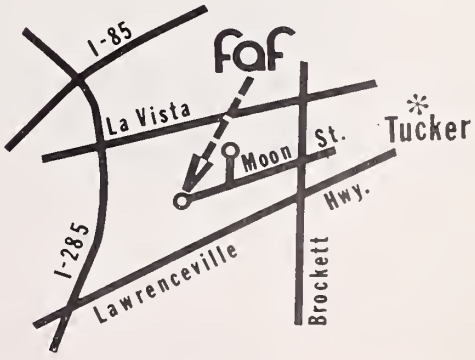


DO ALL DOCTORS DRIVE MERCEDES?

No. Some enjoy the unique experience only a Ferrari delivers.

Driving the 308GTB puts you in an entirely different world of automotive experience. To quote *Autocar*—"All round, one is lost in admiration for the superb quality of the mechanical engineering, the standard of finish of the body and interior details, and the all-round efficiency. It is the best Ferrari we have driven."

Test drive the 308GTB as our guest (it's priced about the same as some Mercedes and Porsche models). Driving will never be the same after you experience Ferrari. You will have known the Ferrari mystique.



faf motorcars inc.

AUTHORIZED FERRARI SALES • SERVICE • PARTS

3862 Stephens Court, Tucker, Ga. 30084 **(404) 939-5464**

This is not a solicitation or an offer to sell or buy any securities. Such an offer is made by prospectus only.

Preferred Partnerships inc.



Re: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Sir;

How much income tax are you now paying? We can help you shelter a portion of your present income---plus show you how you can receive a Tax-Free return.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that gives you a better tax write-off. We have investments in the $5,000-$8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

Regents of the University of California v. Bakke: Must Medical School Admissions Programs Be "Color-Blind"?

ROBERT N. BERG, *Atlanta**

IS IT CONSTITUTIONAL for a medical school to discriminate in its admissions program in favor of members of disadvantaged minorities? *Regents of the University of California v. Bakke*,[1] argued before the United States Supreme Court last month, should provide the answer to this sensitive and complex question, and medical school admissions offices across the country are nervously awaiting the Supreme Court's decision.

The Facts

The University of California at Davis Medical School, dissatisfied with the lack of minority representation among its students that had resulted from the use of traditional admissions criteria, instituted a special admissions program for disadvantaged minority students in 1969. This special admissions program, unlike the regular admission process for nonminority applicants, did not automatically disqualify applicants whose grade point averages or medical aptitude test scores fell below a certain minimum numerical level. The medical school reserved 16 of its 100 admission places for students applying under the special admissions program; applicants for the remaining 84 places were selected by recourse to the regular admission process.

In 1973 and again in 1974, Allan Bakke applied for admission to the medical school;[2] in both instances, he was denied admission, although the University conceded that Bakke would probably have been admitted if there had been no reservation of admission places for minority applicants. Shortly after the second rejection, Bakke filed a complaint against the University. In that complaint, Bakke alleged that he was denied admission to the medical school solely because of his race, that the special admissions program applied separate (i.e., preferential) standards for evaluation of minority student applications, and that the use of separate standards resulted in the acceptance of minority applicants who were less qualified for the study of medicine than Bakke and other nonminority applicants not selected; in short, Bakke claimed that he had been the victim of invidious discrimination because of his race, in violation of the equal protection clause of the Fourteenth amendment to the United States Constitution.

The Supreme Court of California agreed. The Court ordered the University to

* Prepared at the request of the Medical Association of Georgia. Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, 11th Floor, C&S Bank Building, Atlanta, Ga. 30303.

scrap the special admissions program and to admit Bakke to the medical school. Subsequently, the United States Supreme Court agreed to hear the appeal by the University, because of the importance of the issues involved.

The Arguments

The basic argument proffered by the University is that the special admissions program represents a remedial intent on the part of the University to cure the evils of lingering racism generally present in our society and, more specifically, an intent to integrate both the medical school and the medical profession in general. Moreover, it is claimed by the University that the special admissions program is necessary to provide an adequate supply of medical care to disadvantaged minorities. Finally, the University claims that the special admissions program provides the most direct means of combatting discrimination in the area of medical education, and should not be replaced by more indirect and less efficient alternatives.

The gist of Bakke's argument is that the Constitution is "color-blind"; discrimination against *any person* on the basis of race is a violation of the equal protection clause.[3] Therefore, to uphold the special admissions program would "represent a retreat in the struggle to assure that each man and woman should be judged on the basis of individual merit alone, a struggle which has only lately achieved success in removing legal barriers to racial equality."[4] Moreover, he argues that, while the goal of ending discrimination in the area of medical education is laudatory, other means are available which focus less directly on race (e.g. increasing the number of places available in the medical school or instituting remedial education programs for minority students interested in pursuing a career in medicine).

The Potential Effects

Should the Supreme Court determine that the special admissions program violates the equal protection clause, medical school admissions offices across the nation will be forced to revamp their admissions policies to remove any vestige of racial preference. Moreover, a ruling in Bakke's favor could endanger the use of affirmative action programs in other areas, such as employment and voting. In short, the future validity of any program which gives preference to any group, minority or nonminority, whether that group be potential medical or law students, potential job applicants or potential voters, should be decided by the Supreme Court's disposition of the *Bakke* case.

NOTES

1. 18 Cal.3d 34, 553 P.2d 1152, 132 Cal. Rptr. 680 (1976).
2. Bakke, a Caucasian, did not apply for consideration under the special admission program.
3. The Supreme Court has held that members of all races share in the protection afforded by the equal protection clause. See, e.g., *Yick Wo v. Hopkins,* 118 U.S. 356 (1885); *Slaughter-House Cases,* 83 U.S. 36 (1872); *Shelley v. Kraemer,* 334 U.S. 1 (1948).
4. *Bakke, supra,* at 1117.

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972



THE PERFECT GET-AWAY PLACE FOR YOU, YOUR FAMILY, YOUR COMPANY.

MOUNTAIN VIEW CONDOMINIUM VILLAS

Lake Arrowhead announces their brand new Mountain View Condominium Villas. These new Lake Arrowhead Condominiums are the most beautiful to be found anywhere—

- Rustic exterior design
- Central heat and airconditioning
- Fully equipped electric kitchen
- Washer/Dryer included
- Wood burning fireplace
- Wall to wall carpeting
- 2-1/2 baths
- Ample inside and outside storage
- Spacious sun deck
- Spectacular mountain view

Prices begin at $46,900

And here's more for you, after a nominal monthly maintenance charge and reasonable amenity fees!

- Membership in the Lake Arrowhead Country Club
- Championship 18 hole golf course
- Tennis and Swim Club
- 500 acre lake perfect for water sports and fishing
- Riding stables and mountain trails
- Picnic and recreational areas

For complete information and or personal inspection appointment call:

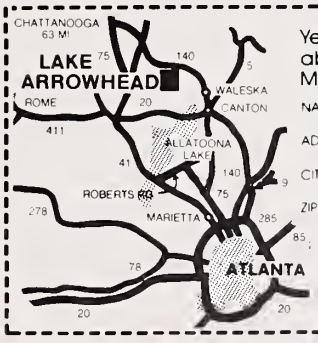
Lake Arrowhead Atlanta Office 266-1002

Or use this handy coupon.

Directions: From I-285 to U.S. 19 through Roswell to GA. 140. Once on GA. 140, follow the signs.

From I-75 go north to Roberts Road exit, the, right to State Hwy. 5 to Canton, then north (left) on Hwy. 140 thru Waleska and follow the sign to Lake Arrowhead.

Lake Arrowhead is only 56 miles from Atlanta, 43 miles from Rome, 38 miles from Marietta, 21 miles from Cartersville, and 12 miles from Canton.



Yes, I am interested in learning more about Lake Arrowhead's brand new Mountain View Condominium Villas.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

LAKE ARROWHEAD

56 miles north of Atlanta...where a sound opportunity awaits you.

Another Diamondhead Corporation Community

THIS AD DOES NOT CONSTITUTE AN OFFER TO SELL IN ANY STATE WHERE SUCH AN OFFER IS PROHIBITED.





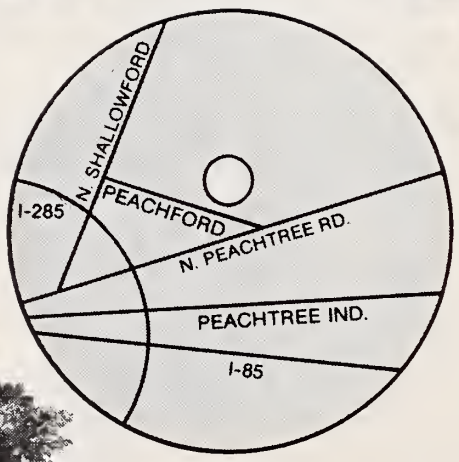








PEACHFORD PERSONNEL PICTURED





PEACHFORD HOSPITAL. A READY REFERENCE.

Peachford is a full-service 102-bed psychiatric hospital providing short, intermediate and long-term treatment programs for adults and adolescents. Hospital care is available to all patients regardless of the severity of their illnesses or of complicating addictions or medical problems.

PROGRAMS

ADULT PSYCHIATRIC PROGRAM: A milieu approach with multiple therapeutic communities designed to provide each patient with the experiences appropriate to his needs.
ADOLESCENT PROGRAM: An intense and highly structured milieu approach, designed to encourage the adolescent's active participation and to promote emotional growth. Among therapies included are daily community meetings, identity groups, individualized school instruction, family therapy, recreational, occupational and music therapy.

ADDICTIVE DISEASE PROGRAM: Alcoholism and drug addiction are considered diseases of the total person in the addiction disease unit of Peachford. Because the disease affects the physical, mental and emotional well-being of the patient, physical detoxification is considered to be only the beginning of the rehabilitation program. All patients are completely withdrawn well before the completion of the 21 to 28 day program and no mind-altering drugs are prescribed for maintenance after discharge. Twenty-four hour admittance is offered.

STAFF: BOAZ HARRIS, M.D., *Medical Director*
CONWAY HUNTER, JR., M.D., *Director, Addictive Disease Unit*
CHARLES D. STEWART, JR., M.D., *Director, Adolescent Services*

The hospital has an open medical staff including 53 psychiatrists, four internists and several other medical specialists. Separate committees supervise the adolescent program, the adult psychiatric program and the alcohol and drug abuse unit.

The professional staff consists of social workers, a training director, recreational therapists, occupational therapists, an art therapist, a music therapist, and teachers for the adolescent school.

The medical director and the directors of various clinical departments have offices in the hospital in order to implement cohesive treatment programs.

PHYSICAL FACILITIES:

Located on 20 acres of rolling, wooded land just north of I-285 in DeKalb County, the hospital is adjacent to the Georgia Mental Retardation Center and near the Shallowford Community Hospital which provides medical support for Peachford Hospital. Peachford is equipped with an X-ray department, a laboratory, emergency treatment room, auditorium, adolescent school, group therapy rooms, occupational therapy shop, year-round swimming pool and athletic fields for volley ball, tennis, basketball, and badminton.

Peachford Hospital is owned by Charter Medical Corporation which also owns the Shallowford Community Hospital and the Metropolitan Eye Hospital in Atlanta. It is accredited by the Joint Commission on the Accreditation of Hospitals.

For complete information or a personal tour of the facilities and explanation of programs, contact:

PEACHFORD HOSPITAL
2151 Peachford Road/Atlanta, Georgia 30366
P.O. Box 81106
Phone (404) 455-3200

TEGA-VERT TABLETS

VERTIGO • MOTION SICKNESS • NAUSEA • MOOD ELEVATION

EACH SUGAR COATED TABLET CONTAINS:

PENTYLENETETRAZOL (Metrazol)	50mg
NIACIN	50mg
DIMENHYDRINATE (Dramamine)	25mg

ADMINISTRATION AND DOSAGE: One or two tablets three or four times daily before or after meals.

INDICATIONS: **TEGA-VERT** is indicated in the symptomatic management of idiopathic vertigo, as well as that associated with Meniere's Syndrome. Arterial Hypertension, Labyrinthitis, Fenestration Procedures, Radiation Sickness and Tonic Effect. **TEGA-VERT** has also been of value in patients with clinical symptoms of senility and functional cerebral impairment as well as symptomatic nausea.

CONTRAINDICATIONS: **TEGA-VERT** should not be used in patients with known history of sensitivity to any of its ingredients. Because of its vasodilating effects, niacin is contraindicated in the presence of arterial hypotension.

PRECAUTIONS AND SIDE EFFECTS: Although there are not absolute contraindications to oral pentylenetetrazol, it should be used with caution in epileptic patients or those known to have a low convulsive threshold. Dimenhydrinate, like other antihistamines may produce sedative side effects, therefore, caution against operating mechanical equipment should be observed. This has not been a significant problem with **TEGA-VERT** since it contains a mild central nervous system stimulant. Niacin can produce transient flushing and sensations of warmth.

HOW SUPPLIED: Bottles of 100 and 1000 tablets.
CAUTION: Federal law prohibits dispensing without a prescription.

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTIBLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

"Kid, this stuff is the bananas."



Experts agree: when it comes to good-tasting banana flavor—without the unpleasant taste of paregoric—the makers of Donnagel®-PG really know their stuff!

For diarrhea

Donnagel®-PG Ⓥ

Donnagel with paregoric equivalent

Each 30 cc. contains:	
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

Now with child-proof closure

A·H·ROBINS

A.H. Robins Company
Richmond, Virginia 23220


CLEAR THE TRACT
Robitussin-DAC
EXPECTORANT
NASAL DECONGESTANT
ANTITUSSIVE
16 FL OZ (1 PT.)
THIS PACKAGE INTENDED FOR REPACKAGING BY PHARMACIST.
630

A·H·ROBINS

INTRODUCING...

NEW ROBITUSSIN®-DAC

for the difficult cough complicated by nasal congestion

*To help clear the lower respiratory tract—the most recommended single expectorant in the U.S.**

Guaifenesin, NF . . . . . 100 mg/5 ml

- Enhances output of less viscid secretions to aid in the removal of inspissated mucus.
- Relieves irritated membranes in respiratory passageways by preventing dryness through increased mucus flow.
- Makes dry, unproductive coughs more productive and less frequent.

For cough suppression...the drug of choice†—

Codeine Phosphate, USP . . . . . 10 mg/5 ml

(Warning: May be habit forming.)

- Reduces severity, frequency and patient awareness of cough.
- Promotes patient comfort.
- Low drug dependence and little risk of side effects in recommended dosage.

For accompanying nasal congestion—

Pseudoephedrine HCl, NF . . . . . 30 mg/5 ml

- An orally effective nasal/sinus decongestant.
- Relieves congestion, reduces edema, promotes drainage.
- 60 mg pseudoephedrine in a 2-teaspoonful adult dose.

Available in pints only. You prescribe the quantity dispensed.

References:
*National Disease & Therapeutic Index, Jan.-Dec., 1976. IMS America Ltd., Ambler, Pa. 1976.
†Amer. Med. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing Sciences Group, Inc., Acton, Mass., 1973, pp. 482-3.

Robitussin®-DAC—Each 5 ml (1 teaspoonful) contains: Guaifenesin, NF 100 mg; Pseudoephedrine Hydrochloride, NF 30 mg; Codeine Phosphate, USP 10 mg (Warning: May be habit forming) in a palatable, aromatic syrup. Alcohol, 1.4 per cent. INDICATIONS: For the temporary relief of cough and nasal congestion as may occur with the common cold or with inhaled irritants. CONTRAINDICATIONS: Hypersensitivity to any of the ingredients, marked hypertension, hyperthyroidism, or in patients who are receiving MAO inhibitors or antihypertensive medication. WARNINGS: Use this product with caution in children under 2 years or in children taking another drug. Prescribe cautiously for patients with persistent or chronic cough such as comes with smoking, asthma, emphysema, or where cough is accompanied by excessive secretions. Caution should be taken in administering this drug to patients with high blood pressure, heart disease or diabetes. In patients with chronic pulmonary disease or shortness of breath, this product should be administered with caution. As with all products containing sympathomimetic amines, use with caution in patients with prostatic hypertrophy or glaucoma. Do not exceed recommended dosage because at higher doses nervousness, dizziness or sleeplessness may occur. May cause or aggravate constipation. NOTE: Guaifenesin has been shown to produce a color interference with certain clinical laboratory determinations of 5-hydroxyindoleacetic acid (5-HIAA) and vanillylmandelic acid (VMA). ADVERSE REACTIONS: Agitation, dizziness, insomnia, palpitations or nausea may occur. In such instances, reduction in frequency and/or quantity of dose is indicated. RECOMMENDED DOSAGE: Adults 1 or 2 teaspoonfuls every four hours, not to exceed 12 teaspoonfuls in a 24-hour period; children 6 to under 12 years, 1 teaspoonful every four hours, not to exceed 6 teaspoonfuls in a 24-hour period; children 2 to under 6 years 1/2 teaspoonful every four hours, not to exceed 3 teaspoonfuls in a 24-hour period; children under 2 years; use as directed by a physician. ALSO AVAILABLE: Robitussin®, Robitussin-CF®, Robitussin with codeine, Robitussin-DM®, Robitussin with dextromethorphan, Robitussin-PE®, Robitussin with phenylpropanolamine and dextromethorphan. Cough Calmers® lozenges (Robitussin-DM in solid form). Robitussin-PE®—Robitussin with pseudoephedrine. A. H. Robins Co., Richmond, Va. 23220.

FREE OFFER—For a 1978 calendar featuring a poster-size, full-color reproduction of this photo of Southern Railway Engine No. 630, write **"Robitussin-DAC"** on your Rx pad and mail to "Train Offer," A. H. Robins Company, 1407 Sherwood Avenue, Richmond, VA 23220.

Doctor—Does this sound like your office?

Symptoms:

1. Office personnel bogged down in filling out a variety of insurance forms for private insurers, Medicaid and Medicare;
2. Delays in sending out up-to-date statements to patients;
3. Problems in maintaining and controlling accounts receivable records;
4. Complaints over headaches caused by excess paperwork;
5. Inconvenient and time-consuming filing systems.

Diagnosis:

paperwork nightmare

Treatment:

Relief of all these symptoms can be accomplished with one simple prescription. For a quick

Cure:

Call now for more information.

data med health systems



10510 Clara Dr., Roswell, Georgia 30075
(404) 992-5100

the association
the association
the association

NEW MEMBERS

Busch, Joseph J. Jr., W-C-D—Act—R
Tri-County Hospital, Fort Oglethorpe 30742

DiJamco, Alice L., Cobb—Act—AN
2540 Windy Hill Rd., Marietta 30062

Hodges, Fred B. III, Whitfield-Murray—Act—ORS
1103 Memorial Dr., Dalton 30720

Jacobs, Norman F., DeKalb—Act—IM
2712 North Decatur Rd., Decatur 30033

Marks, Frank W., Dougherty—Act—IM
P.O. Box 288, Albany 31702

Peel, Jesse R., Cobb—Act—P
3188 Atlanta St. S.E., Smyrna 30080

Reed, Ralph E., Stephens-Rabun—Act—OPH
800 East Doyle St., Toccoa 30577

Tallman, James M., Dekalb—Act—R
Emory University, 1287 Sanden Ferry Dr., Decatur 30033

Tanjuateo, Manuel C., S.W. Georgia—Act—OBG
205 West Main St., Colquitt 31737

West, Fred M., C-D-H—Act—GP
Ambulance Dr., Carrollton 30117

SOCIETIES

The **Georgia Medical Society** Auxiliary had a fashion show staged for them by Belk's Department Store September 29 to help them raise money for their scholarship fund. The event, which was held at Armstrong State's Fine Arts building, was entitled "Design '77."

The **Medical Association of Atlanta** received a $500 cash prize and a plaque for the over-all excellence of their official publication, *Atlanta Medicine*. The awards were given by Sandoz Pharmaceuticals of East Hanover, N.J., whch conducts an annual journalism competition for medically-related publications. The editor and managing editor of *Atlanta Medicine* are Dr. S. Robert Lathan and Eleanor Somerville.

At a hearing held in Albany in early October, James Sullivan, M.D., of Columbus, spoke on behalf of the **Medical Association of Georgia,** in favor of Georgia's creating a new government program to compensate victims of crime. The hearing was conducted by the joint Senate-House Victims of Crime Study Committee, created by the 1977 General Assembly.

PERSONALS

First District

Wendall Wallace Buckhaults, M.D. and **Dan H. Willoughby, M.D.,** both of Savannah and former chiefs of staff at Candler General Hospital, have been appointed to four-year terms on the hospital's Board of Trustees.

C. V. Costa, M.D., of Savannah, has been named diector of the Rincon Medical Professional Offices in Rincon.

Fourth District

Decatur physician **Herbert A. Hudgins, M.D.** is the new Director of Health Services for Gwinnett County. A graduate of the Emory University School of Medicine, Dr. Hudgins has served as health officer in the Philippines, Haiti, El Salvador and as area medical officer in charge of Indian health in the western United States.

Fifth District

William R. Elsea, M.D., director of the Fulton County Health Department, has been elected vice-president of the National Association of County Health Officials (NACHO), an organization established to promote new ideas and an exchange of information between county health officers, health services agency administrators and local health planners.

Forensic pathologist **Saleh Abbas Zaki, M.D.,** of Atlanta, ended a four-year tenure with the Fulton County Medical Examiner's office in October to become an associate professor of pathology at the University of Alabama. One out of a total of 150 forensic pathologists practicing in the U.S., Dr. Saki, a native of Egypt, received his M.D. from the University of Cairo in 1959, his doctorate from the University of Birmingham (England), and has held teaching positions in Britain, Ireland, the University of Calgary, Alberta, Can., and Emory University.

First Georgia Leasing, Inc.

Write your own prescription. Our leases are tailored to your individual needs.

✓12-48 MONTH LEASES ✓EQUITY OR NON-EQUITY
✓PERSONAL OR BUSINESS USE
✓20 YEARS EXPERIENCE IN THE AUTOMOTIVE FIELD

That's Why Our Name Is "First Georgia Leasing

WE LEASE ALL MAKES FOREIGN & DOMESTIC

971-8838

For Practice Management Information Systems...

Call The Specialists Call Systemedics

- FOR improved cash flow and financial control
- FOR automatic processing of patient statements and insurance information
- FOR improved patient management through use of our Problem Oriented Record
- FOR continuing service and management assistance

Serving medical practices exclusively

Systemedics of Georgia
P.O. Box 28055
Atlanta, Ga. 30328
(404) 252-3835

Seventh District

Cardiologist **J. Gordon Barrow, M.D.,** of Douglasville, was presented an award by the Georgia Heart Association, during its 29th meeting and scientific sessions, for his distinguished achievement in the fight against heart disease. Dr. Barrow, a former president of the GHA, is a private practitioner in Douglas County and a clinical professor of medicine (cardiology) at Emory University School of Medicine.

Tenth District

Beverly Belk, M.D., of Augusta, conducted a two-day seminar on child abuse in September in Jesup. Dr. Belk, an associate professor of pediatrics at Georgia Medical College, spoke to school administrators, physicians, and the general public about child abuse and how and when to report it.

Ernest J. Jones, M.D., of Covington, has completed continuing education requirements to retain active membership in the American Academy of Family Physicians. The requirements call for a completion of 150 hours of accredited continuing medical study every three years.

DEATHS

Rick Steven Shuman

Rick Steven Shuman, M.D., 28, of Elberton, died September 16, following a brief illness. Dr. Shuman, a graduate of the Medical College of Georgia, was serving as secretary to the Elbert County Medical Society at the time of his death.

Surviving are his wife, Mrs. Brenda Burton Shuman, one daughter, his mother and father, one brother, two sisters, and his maternal grandmother.

Richard H. Smoot

Past president of the DeKalb County Medical Society, Richard H. Smoot, M.D., died October 2 at the age of 65. Dr. Smoot, who was named "Outstanding Doctor of the Year" by the Georgia Nurses Association in 1973, was the first chief of surgery at DeKalb General Hospital and was, for a number of years, an assistant professor of gross anatomy at the Emory University School of Medicine.

Surviving are his wife, Mrs. Mary Dodgen Smoot, one daughter, one son, one brother, and three grandchildren.

New Medicare Telephone Number

Prudential Medicare B has changed its telephone number for physician calls to (404) 325-5614. Physicians are asked to give the switchboard operator their names or group names, if applicable. Prudential hopes this new setup will provide faster and more efficient handling of telephone inquiries.

Breakdown of DMA Expenditures

The Department of Medical Assistance will spend $340 million in benefits during this fiscal year 1977. These expenditures break down as follows:

	Expenditures	*% of Total*
Hospital services	$ 85,971,000	25.3
Physician services	26,942,000	7.9
Drugs	31,656,000	9.3
Nursing home services	149,976,000	44.1
Dental services	9,845,000	2.9
Other services	35,681,000	10.5

Of the $31 million spent on all drugs, $9,610,000 will be spent on 20 drugs. These 20 most-frequently prescribed drugs are:

	% of Total Drug Expenditures
Valium	5.52
Lanoxin	1.28
Lasix	1.96
Mellaril	2.94
Empirin compound/codeine	1.44
Phenobarbital	0.55
Donnatal	0.86
Motrin	2.80
Aldomet	1.91
Darvocet-N	1.09
Indocin	2.18
Insulin	1.26
Serapes	1.34
Elavil	1.63
Benadryl	0.52
Thorazine	0.83
Dilantin	0.66
Tylenon-codeine	0.76
Dalmane	0.54
Antivert	0.85

The Department wants to ensure that the quality of patient care is preserved even though the Department's responsibility to the taxpayer is recognized.

In December, 1976, Governor Busbee appointed Mr. David Poythress to head the troubled Medicaid Program. One of Commissioner Poythress' first steps was to work to appoint the Governor's Formulary Committee. The Committee is broadly based with representatives from the Medical Association of Georgia, the Georgia State Medical Association, the State medical schools, the Georgia Pharmaceutical Association, and the State pharmacy schools.

This Committee's focus has shifted from the development of a limited formulary to alternative measures of curbing the rise in drug costs.

Fleming L. Jolley, M.D.
Immediate Past President, MAG

CORRECTION

On page 616 of the August *Journal,* Alex F. Robertson III, M.D., is shown as being from Atlanta. In fact, Dr. Robertson is Chairman of Pediatrics, Medical College of Georgia, Augusta 30902.

EAC

Aircraft Acquisition/Sales
Free Consultation

J. L. (Larry) Scott
J. W. (Pete) Smith

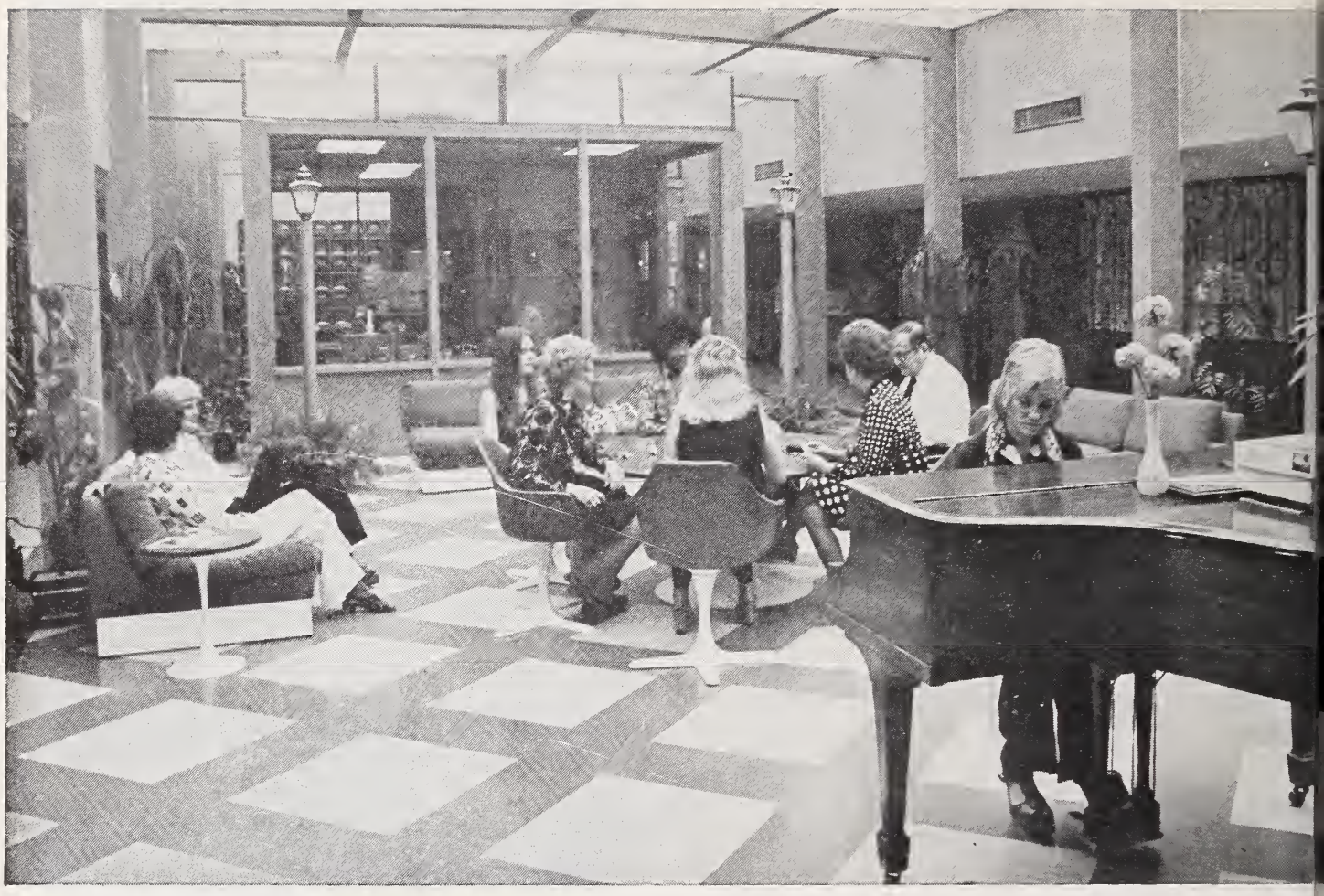
Executive Aviation Corporation
1951 Airport Road, Atlanta, Georgia 30341
404/458-8956

WHEN YOU NEED PROFESSIONAL ADVICE

instead of a sales spiel

If your dollars and other tangible assets are not working for a maximum return, do you know what your losses really are? Do you know how the Tax Reform Act of 1976 is affecting your financial situation today? A financial check-up is one way to find out. When an evaluation of your personal financial condition is indicated, we can help.

CONSOLIDATED PLANNING CORPORATION
Registered Investment Advisors
148 International Blvd., Suite 801
Atlanta, Georgia 30303
Telephone (404) 659-2920



METROPOLITAN PSYCHIATRIC

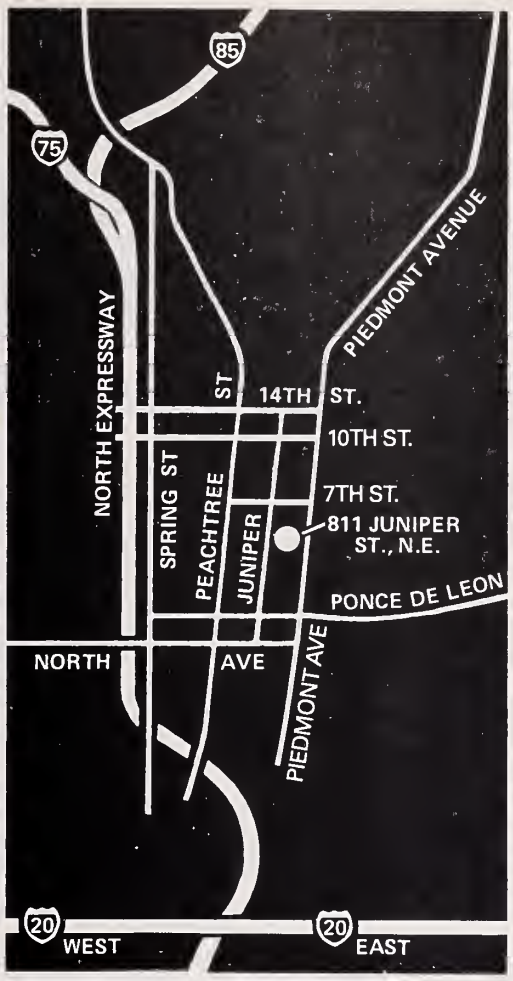
METROPOLITAN PSYCHIATRIC CENTER, centrally located in midtown Atlanta, provides comprehensive services for adult and adolescent patients in the areas psychiatry and alcohol and drugs. Inpatient care, outpatient care and partial hospitalization programs available at the Center.

In the Psychiatric Program, the attending psychiatrist determines from the comprehensive services available the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

ıily Counseling
'chological Testing
ial Work Services
ıcational Tutoring
:ational Rehabilitation Counseling
Radiology Services
ivity Therapy Programs including Occupational
rapy, Recreational Therapy and Art Therapy

Georgian Clinic Program, directed towards the
very of persons addicted to alcohol or drugs, offers a
ured yet personalized experience drawing upon a
range of treatment modalities. Through the

Grumet, M.D. **Custis L. Rosser, M.H.A.**
al Director **Administrator**

e Dominick, M. Div.
r, Georgian Clinic Program

combined resources of the Center for Psychotherapy Inc., the Atlanta Internal Medicine, P.A., and the Metropolitan Psychiatric Center staff, the following services are included:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling
- Pastoral Counseling Services

Additional information on the Psychiatric Program may be obtained by contacting Dottie Fitchett, Admissions. For information on the Georgian Clinic Program, call 876-8655. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

politan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
niper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

When your patients have problems they turn to you. . . .

When your practice has problems whom do you turn to?

FHC
Family Health Care, Inc.

Family Health Care, Inc. *provides a comprehensive range of management services for the diagnosis and treatment of practice problems.*

- Organization
- Patient Flow
- Medical Records
- Personnel Management
- Administration
- Financial Management
- Trendline Evaluation
- New Practice Development
- Planning for Practice Expansion

For further information about our services contact:

Don Jones, M.B.A.
Regional Director
Family Health Care, Inc.
6065 Roswell Rd., Suite 320
Atlanta, Georgia 30328
(404) 256-4825

Estes Surgical Supply Company

AMERICAN SURGICAL TRADE ASSOCIATION ASTA

—SINCE 1908—
EXAMINATION FURNITURE
OFFICE FURNITURE
LAB SUPPLIES
ELECTROCARDIOGRAPHS
PHYSIOTHERAPY APPARATUS
SURGICAL SUPPLIES & INSTRUMENTS
SUNDRIES
X-RAY SUPPLIES
COMPLETE OSTOMY LINE

351-2011
890 CHATTAHOOCHEE AVE., NW
(NEAR I-285 & I-75 N.)

"Ostomy Is Our Only Business"

The South's largest stock of post-op and reusable pouches and accessories for all ostomies—UPS delivery.

The only custom care center, operated by CERTIFIED ENTEROSTOMAL THERAPISTS.

Over 25 years experience in ostomy care and rehabilitation.

Contact Mrs. Jane Walker, E.T.
A founder of Enterostomal Therapy

The Ostomy Center, Inc.

Enterostomal Therapy Service
5675 Peachtree Dunwoody Rd.
Atlanta, Georgia 30342
404-256-4444

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members—$5.00** for the first 50 words; $.10 per word for each additional word. **Non-members—$15.00** for the first 50 words; $.10 per word for each additional word. *Charges are payable in advance.* Copy must be typed and received by the Publisher no later than the 25th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535, INWATS in Georgia (800) 282-0224.

PHYSICIANS NEEDED

FAMILY PRACTICE AND OB/GYN opportunity for solo or group practice in community of approximately 9,000 located in east-central section of South Carolina. Partnership arrangement guarantees $50,000. Forty-eight-bed hospital serves local area with easy access and referral to new regional medical center 20 miles away. Six FPs/GPs presently in community. Contact J. D. Whitehead, M.D., Lake City, S.C., (803) 394-2238.

EMERGENCY ROOM PHYSICIAN—450-bed general hospital, Southwest Georgia; active emergency room service. Contact Administrator, Phoebe Putney Memorial Hospital, Albany, Ga. 31702, (912) 883-1800.

OUTSTANDING OPPORTUNITY in West Georgia for General Practitioner and/or internist (two positions available). Convenient location with good schools and recreation facilities. Population has high percentage of insurance coverage and is ready to offer good support with modern facilities and above-average hospital. Call E. H. Rivers (404) 537-3862; after 6 pm 537-2092.

FAMILY PRACTICE PLUS salaried half-time position available for local school project in Albany. For good salary and excellent practice opportunity, contact Dougherty County Medical Society, P.O. Box 1828, Albany, Ga. 31702.

REAL ESTATE

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital; 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Write Box 10-B c/o the *Journal*.

WILL SELL, IN WHOLE OR PART, 95 acres of farmland, West Cobb County near MacLand; 25-29% down, balance on any reasonable terms. Write: Physician, P.O. Box 54778, Atlanta, Ga. 30308.

NEED A MOUNTAIN VACATION RETREAT where you can hear crickets, frogs and falling leaves? Maybe even snow? Golf, tennis, swim, antique, loaf seriously, ski in season (or peer out at the skiers from the warmth of the log fire in the lodge). Three-bedroom, 2-bath, fully carpeted chalet at Sky Valley, Ga. has dishwasher and Disposall, sleeps 8. Reasonable by day or week. Contact: Dr. Reuel E. Hamilton, Box 311, Marietta, Ga. 30061; telephone (404) 422-7631/1488.

MEDICAL OFFICE SPACE TO SHARE with established GP, internist. Ideal location, busy intersection in east Marietta near I-285 and I-75. Will consider part-time or full-time. No investment required. Very suitable for second office in such fields as ophthalmology, dermatology, pediatrics, Ob-Gyn, podiatry, radiology or laboratory. Ability to expand office if needed. Call (404) 973-8300.

BEAUTIFUL GLASS PAVILION HOUSE for sale with 8 acres of land north of Atlanta. Only home like this in the state. Huge great-room; three fireplaces, one in massive kitchen; full studded basement. Call (404) 993-4260.

SERVICES

PHYSICIANS AUTO LEASING SERVICE. A state-wide leasing service is offered to physicians and other health professionals. First Georgia Leasing gives preferred rates on luxury and prestige cars and leases all makes, foreign and domestic. Special rates quoted for multiple group-practice leases. Call Tom Lawless (404) 971-8838.

MONEY AVAILABLE. Unsecured personal loans of $5,000 to $35,000 with up to 5 years to repay. No prepayment penalties. For doctors—established or in training—, military, college educators, business executives. Loans made anywhere in Georgia and in most other states. Can be handled by mail. Write Hosmer and Associates, P.O. Box 28526, Atlanta, Ga. 30328, or call (404) 255-0714.

MISCELLANEOUS

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.;* severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable

ROCHE Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC.

Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® IV
chlordiazepoxide HCl/Roche



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

Index to Advertising

Vol. 66 November 1977 No. 11

Walter Ballard Optical 902
Brawner Hospital, Inc. 848
Burroughs Wellcome Co. 896
Capital Automobile Company 850
Chris Motors 868
Classified Advertising 923
Coca-Cola Company 860
Consolidated Planning Corporation 919
Creditor's Mercantile 864
Data Med Health Systems 916
Design House 859
Dickey-Mangham Company 855
Eager and Simpson 908
Estes Surgical Supply Company 922
Executive Aviation Corporation 919
Faf Motorcars 905
Family Health Care, Inc. 922
First Georgia Leasing 918
Georgia Army National Guard 890
Hickman Datsun 855
Hill Crest Hospital 902
Lake Arrowhead 888, 909
Lakeview Hospital 902
Eli Lilly and Company 856
Loma Linda 895
Medical Oxygen Service, Inc. 854
Metropolitan Psychiatric Hospital 920, 921
North DeKalb Office 847
Ortega Pharmaceutical Company 912
The Ostomy Center 922
Peachford Hospital 910, 911
Peachtree and Parkwood Hospitals 901
Potter-Holden & Company 854
Practice Productivity, Inc. 893
Preferred Partnerships, Inc. 906
Qualicare, Inc. 902
A. H. Robins Co. 913, 914, 915
Roche Laboratories 846, 924, 925, 927, 928
Roerig 850, 851, 893
Smith Kline & French 894
Systemedics of Georgia 918
U.S. Air Force 853
U.S. Navy 854
Valley Psychiatric Hospital 912
Warner Chilcott 852
Weight Watchers of Greater Atlanta 850
Willingway Hospital 855

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.**, 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication only if requested. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

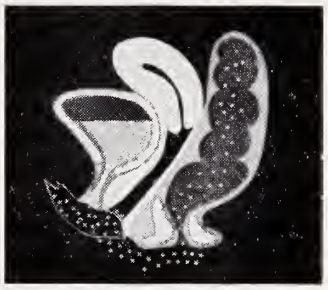
MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack

U. OF CALIF., SAN FRANCISCO
SAN FRANCISCO, CA. 94143



ROCHE

Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Entero bacteriaceae* in the bowel without the emergence of resi tant organisms. Thus, Bactrim reduces the risk of introi colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

JOURNAL
of the medical association of
georgia
DECEMBER / 1977



LIBRARY
U.C. SAN FRANCISCO
JAN 4 1978

A character all its own.



Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Make the most of your precious hours in our T-Tail time machines.



Piper Lance II, Turbo Lance II

For further information about our full line of Piper Airplanes, call Mike Pickett, Pat Epps or Cliff Hale.

EPPS
AIR SERVICE

Georgia's largest Piper dealer/
DeKalb-Peachtree Airport • Atlanta

(404) 458-9851

Brawner Hospital, Inc.

Established in 1910
3180 Atlanta Rd.
Smyrna, Ga. 30080
(404) 436-0081



Brawner is a private hospital for the care of a wide variety of emotional disorders. The hospital combines years of experience (it was founded in 1910) with the most modern and up-to-date facilities. Located in Smyrna, Georgia, just northwest of Atlanta, Brawner has retained the quiet atmosphere of the country on its spacious 80 acres, in spite of the fact that the town around it has changed from rural to urban. Here you find a dynamic therapeutic community in which every aspect of the patient's varied activities are a significant part of the treatment effort. Under the direction of the patient's therapist, an alert and sensitive staff communicates and coordinates perceptions of the patient's behavior and personality and fashions a treatment program tailored to the individual.

Services are provided by the Center for Interpersonal Studies, P.A., where psychiatric, medical and psychological services are available. Each patient is assigned to a therapist from the professional staff and the therapist coordinates the treatment program while maintaining liaison with the patient's family and his referring physician. The treatment program includes both individual and group psychotherapy, and the therapeutic milieu which affords a structure and the close coordination of the members of the treatment team. An Activities Therapy department allows the patient to explore his interests and express his energies in constructive rehabilitation efforts. The philosophy of this department is to coordinate with the patient's over-all planned treatment program which is aimed at enabling him to readjust to a responsible role in his home community. The various medical specialties are represented on the consulting staff of the hospital.

Admission to the hospital is arranged on request from the patient's physician or a referring agency. Patients with various forms of emotional illnesses are accepted, with the usual minimum age being 13 years. Some enter the hospital for a brief period of inpatient evaluation, some for a brief period of treatment as an intervention into a personal or family crises, and others are admitted for intermediate or longer-term intensive treatment.

Education is extremely important for the adolescent patient. In recognition of this, there is a school in the hospital which offers high school courses under the direction of a full-time teacher who is fully qualified to work with emotionally disturbed young people. Liaison is maintained with the patient's home school and every effort is made to help him progress in his schooling to the best of his ability.

Inquiries about the hospital and treatment facilities are welcomed. Additional information is available on request. Whenever possible, arrangements are made for prospective patients and their families to visit the hospital for a pre-admission interview. Correspondence regarding admission should be directed to Dr. Mark A. Gould, M.D., Medical Director. Emergency admissions can be arranged by contacting the on-call staff psychiatrist.

JOURNAL
of the medical association of georgia

contents

VOLUME 66, NUMBER 12

EDITOR
Edgar Woody Jr., M.D.
MANAGING EDITOR
Sharon T. Smith
ASSISTANT MANAGING EDITOR
Caffilene Allen
ADVERTISING MANAGER
Mary Coté
BUSINESS MANAGER
L. B. Storey
CONTRIBUTING EDITORS
Herbert E. Alden, M.D., Atlanta
Preston D. Ellington, M.D., Augusta
J. Willis Hurst, M.D., Atlanta
Donald J. McKenzie, M.D., Thomasville
Arthur J. Merrill, M.D., Atlanta
Peter L. Scardino, M.D., Savannah
Patrick C. Shea, Jr., M.D., Atlanta
Robert H. Vaughan, M.D., Columbus
A. Calhoun Witham, Augusta
PUBLICATIONS COMMITTEE/EXECUTIVE COMMITTEE OF THE BOARD OF DIRECTORS
Robert E. Perry Jr., M.D., Brunswick
President
Carson B. Burgstiner, M.D., Savannah
President-Elect
Fleming L. Jolley, M.D., Atlanta
Immediate Past President
Milton I. Johnson, M.D., Macon
First Vice President
L. Newton Turk III, Atlanta
Second Vice President
Joe C. Stubbs, M.D., Valdosta
Chairman of the Board of Directors
Earnest C. Atkins, M.D., Atlanta
Secretary
James H. Sullivan, M.D., Columbus
Treasurer
L. C. Buchanan, M.D., Decatur
Speaker of the House
Jack F. Menendez, M.D., Macon
Vice Speaker of the House
THE ASSOCIATION
938 Peachtree Street, N.E.
Atlanta, Georgia 30309
Phone: 404-876-7535
WATS Line: 1-800-282-0224
James M. Moffett, Executive Director
J. Sherwood Williams, Assistant Executive Director—Administration
Stephen L. Daniel, Assistant Executive Director—Education
Rusty Kidd, Director of Legislative Activities
Kenneth M. Williams, Director of Public and Professional Relations
Lola Inman Brown, Administrative Assistant to the Executive Director

Second Class postage paid at Atlanta, Georgia, and additional mailing offices. Publication No. 284700.

Established 1911. Owned and edited by the Medical Association of Georgia. Published monthly under the direction of the Council of the Association.

Copyright, 1977, Medical Association of Georgia.

The subscription price per year for members of the Medical Association of Georgia is $5, included in the annual membership dues. The subscription price per year for nonmembers is $7 in the United States, Canada and Mexico, and $8 in other countries. Single copies are $1.
Printed by The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251.

SCIENTIFIC ARTICLES

947 Saturated Animal Fat, Plasma Cholesterol and Coronary Heart Disease
W. O. Caster, Ph.D.
Anna V. A. Resurreccion, Ph.D.
951 Transphenoidal Microsurgery for Pituitary Tumors
George T. Tindall, M.D.
C. Scott McLanahan, M.D.
James H. Christy, M.D.

SPECIAL ARTICLES

943 Primary Care Physician Manpower Study: Present and Projected Need
Wells Riley, M.D.
H. Gordon Davis Jr., M.D.

1977 INDEX

996 Author's Index
996 Subject Index

EDITORIALS

959 MAG 1977
Edgar Woody Jr., M.D.
960 Access to Health Care Committee at Work
M. C. Adair, M.D.

FEATURES

963 President's Letter/Happy Holidays!
Robert E. Perry Jr., M.D.
965 I've Told This Before/An Act of Courage
J. G. McDaniel, M.D.
967 Cancer Page/Help Is Available in the Care of Your Patient with Cancer
J. Moultrie Lee, M.D.
969 Heart Page/Current Indications for Coronary Artery Angiography and Bypass Surgery—Part 2
Gordon C. Miller, M.D.
973 Legal Page/Medicare-Medicaid Anti-Fraud and Abuse Amendments
Richard H. Vincent
Robert N. Berg

THE ASSOCIATION

977 New Members
977 Societies
977 Personals
978 Letter to the Editor
978 Practice Management Workshop Scheduled
979 New Staff Members
981 MAGNET 77: An Overwhelming Success
983 Physician Recruitment Conference/Pre-Practice Seminar
985 MAG President Speaks Out Against NHI

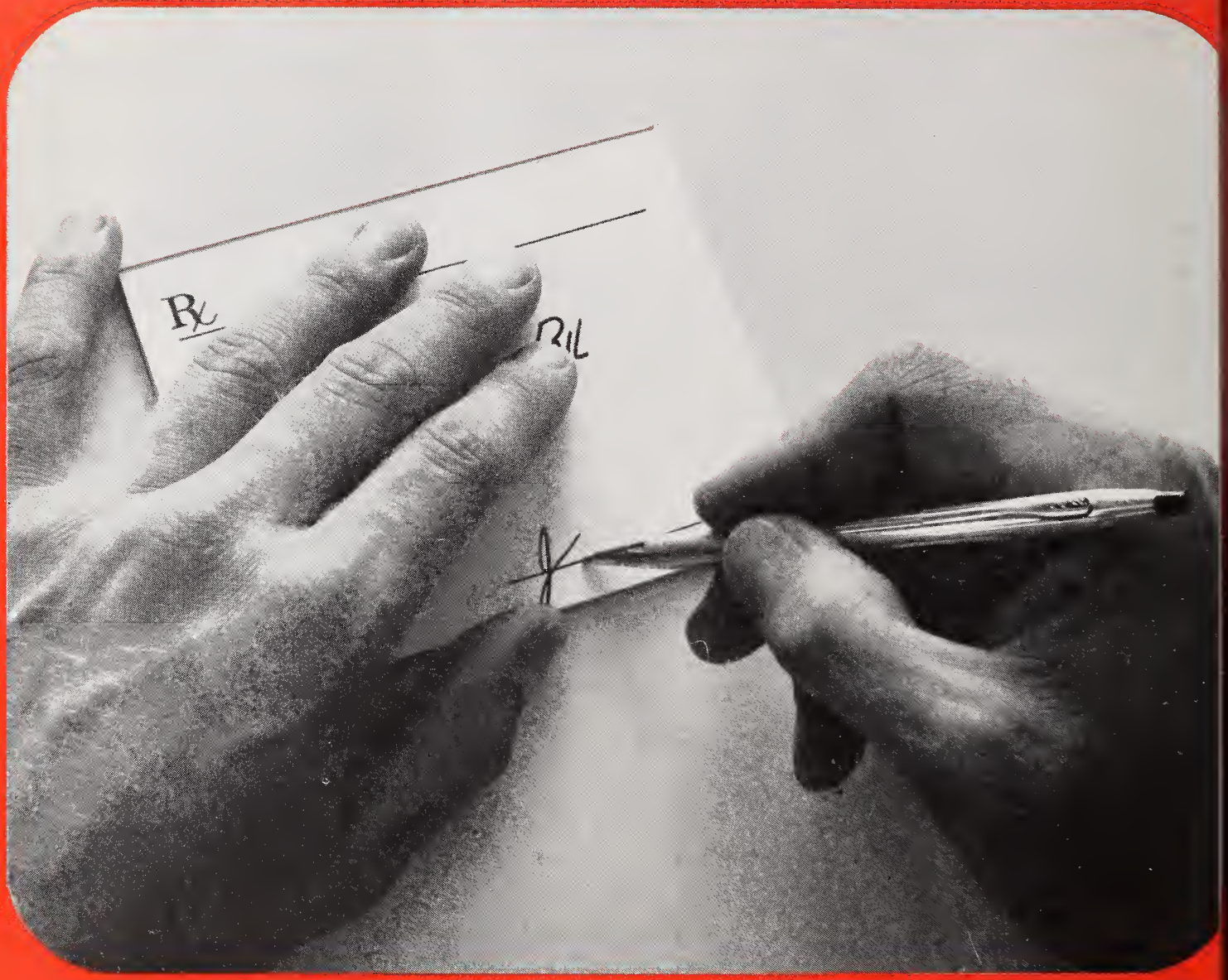
NEWS

937 Medical Meeting Calendar
949 National Health Insurance Blasted
958 *Journal* Advertisers
978 Practice Management Workshop Scheduled
985 MAG President Speaks Out Against NHI
1000 Index to Advertising
1000 Manuscript Information

COVER

The *Journal* staff wishes you and yours a joyous holiday season and the happiest year ever!

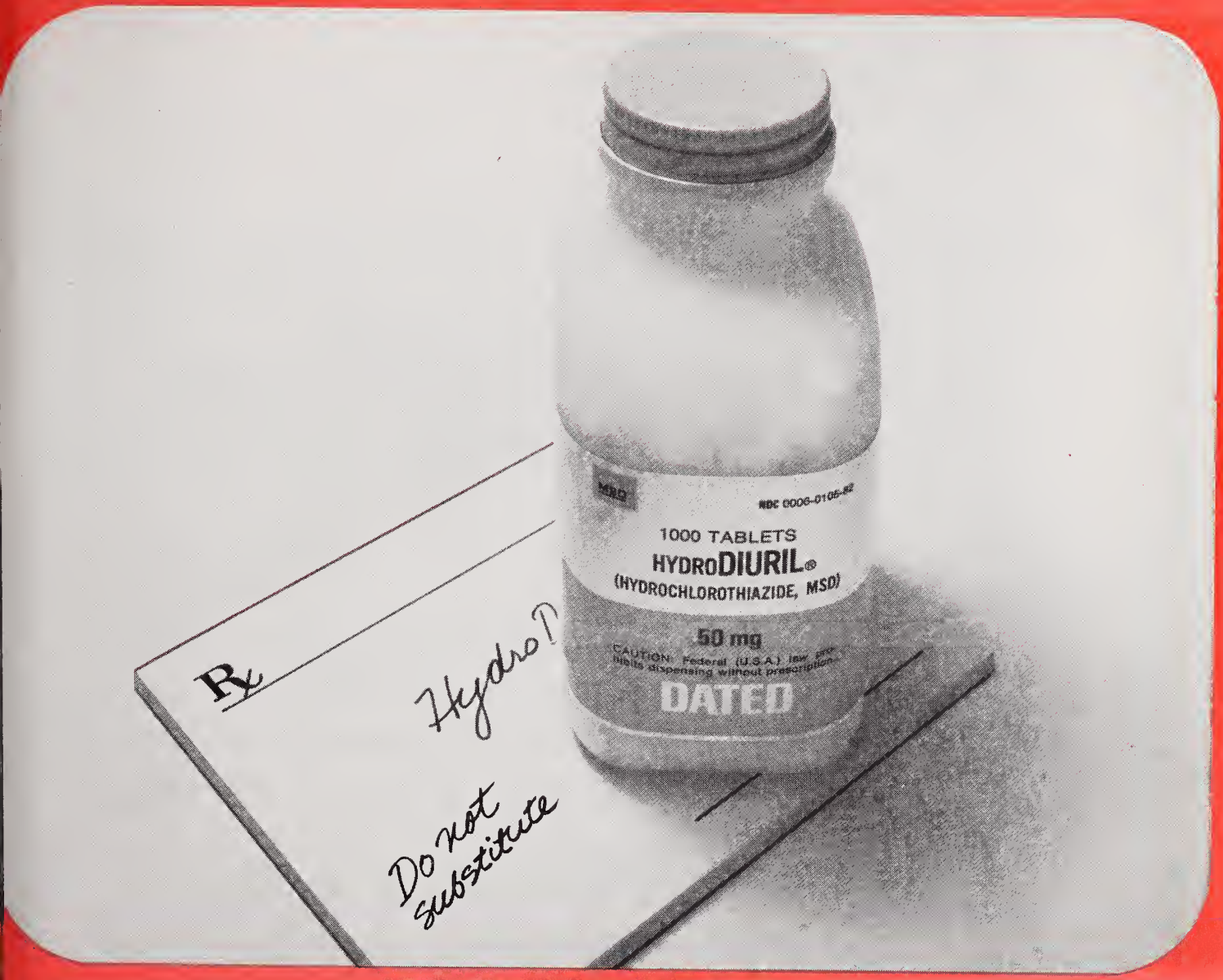
There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

airment becomes evident, consider withholding or discontinuing uretic therapy. Thiazides may decrease serum PBI levels without gns of thyroid disturbance. Calcium excretion is decreased by iazides. Pathologic changes in the parathyroid gland with hyper- lcemia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

dverse Reactions: *Gastrointestinal System*—Anorexia; gastric ir- ation; nausea; vomiting; cramping; diarrhea; constipation; jaundice trahepatic cholestatic jaundice); pancreatitis; sialadenitis.

entral Nervous System—Dizziness; vertigo; paresthesias; headache; nthopsia.

ematologic—Leukopenia; agranulocytosis; thrombocytopenia; lastic anemia.

rdiovascular—Orthostatic hypotension (may be aggravated by ohol, barbiturates, or narcotics).

persensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing giitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress luding pneumonitis; anaphylactic reactions.

her—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; akness; restlessness; transient blurred vision.

henever adverse reactions are moderate or severe, thiazide dosage ould be reduced or therapy withdrawn.

te: When used with other antihypertensive drugs, careful observa- ns for changes in blood pressure must be made, especially during ial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6HD04(528)

MSD
MERCK SHARP & DOHME

In hypertension

TABLETS: 25 mg, 50 mg, and 100 mg

HydroDIURIL®

(HYDROCHLOROTHIAZIDE|MSD)

This is not a solicitation or an offer to sell or buy any securities. Such an offer is made by prospectus only.

Preferred Partnerships inc.



Re: 1. Tax Shelter
2. Tax-Free Income
3. Equity Build up

Dear Sir;

How much income tax are you now paying? We can help you shelter a portion of your present income --- plus show you how you can receive a Tax-Free return.

We are in the business of setting up limited partnerships in income-producing properties, one of the few investments left that gives you a better tax write-off. We have investments in the $5,000-$8,000 range.

For further information, call 261-8025.

Sincerely,

Preferred Partnerships inc.

Suite 850 • 3355 Lenox Rd. • Atlanta, Ga. 30326 • (404) 261-8025

Medical Meeting Calendar

JANUARY

11-13—*Louisville, Ky.;* **MEDICAL ETHICS;** Category 1 Credit; Contact: Frank R. Lemon, M.D., University of Kentucky, College of Medicine, Continuing Education, Lexington, Ky. 40506.

12-13—*Atlanta;* **REHABILITATION OF THE RENAL DISEASE PATIENT;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Emory University School of Medicine, Atlanta 30322.

12, 19, 26—*Atlanta;* **SEMINAR IN DREAMS;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., NE, Atlanta 30326.

17, 24, 31—*Atlanta;* **SEMINAR IN PSYCHOTHERAPY;** Category 1 Credit; Contact: Extension Committee, Atlanta Psychoanalytic Society, Suite 911, 3400 Peachtree Rd., NE, Atlanta 30326.

18-19—*Augusta;* **HYPERTENSION: RECENT ADVANCES IN DRUG TREATMENT;** Category 1 Credit; Contact: Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

26—*Atlanta;* **DIALYSIS AND TRANSPLANTATION FOR END-STAGE RENAL FAILURE IN DIABETIC PATIENTS;** Contact: The Lowenberg Clinic, P.A., 4444 Austell Rd., Austell 30001.

31-Feb. 1—*Atlanta;* **PRACTICE MANAGEMENT WORKSHOP: ESTABLISHING YOURSELF IN MEDICAL PRACTICE;** Contact: Stephen L. Daniel, Ph.D., MAG, 938 Peachtree St., N.E., Atlanta 30309.

FEBRUARY

1—*Atlanta;* **THE STANFORD APPROACH TO WEIGHT CONTROL;** Contact: Donna Mull, Gwinnett County Health Education Project, c/o Joan Glancy Memorial Hospital, Duluth, PH: 404/476-3751, ext. 259.

2-4—*Augusta:* **MAKING SURGICAL DECISIONS;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

3-4—*Lexington, Ky.;* **BURN SYMPOSIUM;** Category 1 Credit; Contact: Frank R. Lemon, M.D., University of Kentucky, College of Medicine, Continuing Education, Lexington, Ky. 40506.

7—*Fort Oglethorpe*—**PEDIATRICS;** Category 1 Credit; Contact: Hutcheson Memorial Tri-County Hospital, Fort Oglethorpe; Division of Continuing Education, Medical College of Georgia, Augusta 30901.

8-9—*Atlanta;* **SECOND ANNUAL SYMPOSIUM ON PERINATAL DISEASE;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory University School of Medicine, Atlanta 30303.

9-10—*Atlanta;* **MOBILITY ASSISTIVE DEVICES;** Category 1 Credit; Contact: Samuel B. Chyatte, M.D., Bonnie Blossom, RPT, Emory University School of Medicine, Atlanta 30322.

9-10—*Augusta;* **CLINICAL PSYCHIATRY;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

13-17—*Savannah;* **CARDIOLOGY FOR THE CLINICIAN;** Category 1 Credit; Contact: Glen E. Garrison, M.D., Division of Continuing Education, Medical College of Georgia, Augusta 30901.

16-19—*Atlanta;* **GEORGIA PSYCHIATRIC ASSOCIATION ANNUAL SPRING SCIENTIFIC MEETING;** Category 1 Credit; Contact: Harold L. McPheeters, M.D., 130 Sixth St., N.W., Atlanta 30313.

19-22—*New Orleans;* **46th ANNUAL ASSEMBLY OF THE SOUTHEASTERN SURGICAL CONGRESS;** Contact: Anne Glade, The Southeastern Surgical Congress, 315 Boulevard, N.E., Suite 500, Atlanta 30312.

23-25—*Atlanta;* **AN UPDATE IN THE CURRENT CONCEPTS IN HAND MANAGEMENT;** Category 1 credit; Contact: Lamar L. Fleming, M.D., Luis O. Vasconez, M.D., Michael Brown, OTR, Emory University School of Medicine, Atlanta 30322.

24—*Savannah;* **DAY OF CANCER;** Contact: American Cancer Society, Chatham County Unit, P.O. Box 14356, Savannah 31406.

24-25—*Durham, N.C.;* **FOURTEENTH ANNUAL E. C. HAMBLEN SYMPOSIUM IN PERINATAL MEDICINE;** Category 1 Credit; Contact: Carlyle Crenshaw, Jr., M.D., Box 3358, Duke University Medical Center, Durham, N.C. 27710.

25-Mar. 4—*Snowmass, Colorado;* **THIRD ANNUAL SNOW JOB IN GYNECOLOGY AND OBSTETRICS;** Category 1 Credit; Contact: John D. Thompson, M.D., Emory University School of Medicine, Atlanta 30322.

27-Mar. 1—*Augusta;* **PULMONARY DISEASES;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/828-3967.

MARCH

1-3—*Atlanta;* **SEXUAL COUNSELING OF ADULTS WITH DISEASE OR DISABILITY;** Category 1 Credit; Contact: J. Robin deAndrade, M.D., Emory University School of Medicine, Atlanta 30322.

2-3—*Pine Mountain;* **PULMONARY SYMPOSIUM V (sponsored by W. Central Branch, Georgia Lung Assoc.);** Category 1 Credit; Contact: Philip Brewer, M.D., The Medical Center, Columbus.

5-8—*Atlanta;* **ATLANTA GRADUATE MEDICAL ASSEMBLY;** Category 1 Credit; Contact: Wynnell S. Hopkins, Exec. Secretary, Atlanta Graduate Medical Assembly, 875 West Peachtree St., N.E., Atlanta 30309, PH: 881-6128.

7-10—*Durango, Colorado;* **EMERGENCY MEDICINE;** Category 1 Credit; Contact: Dr. Gerald T. Chambers, Division of Continuing Education, Medical College of Georgia, Augusta 30901, PH: 404/-282-3967.

22-26—*Atlanta;* **ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION;** Category 1 Credit; Contact: Mrs. G. M. Coleman, 1911 Jefferson Davis Hwy., Suite 905, Arlington, VA 22202.

For additional information on these and other meetings, contact MAG, Division of Education 404/876-7535.

WEIGHT WATCHERS®

Wishes to thank the many members of the Medical Profession who have recommended The Weight Watchers Program to their patients in their treatment of obesity.

Sincerely,

Anne & Harry Friedman

Co-Directors

(404) 373-5731 or Dial Free 1-800-282-4565

"WEIGHT WATCHERS" AND ® ARE REGISTERED TRADEMARKS OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y.
©WEIGHT WATCHERS INTERNATIONAL, 1977

Practice where the big premium is on medical care.

Not on high overhead. Or paperwork. Or any of the other hassles that keep chipping away at your clinical time.

If you want more out of your medical career, consider what the Navy can offer. A ready-made practice where patients' medical care is independent of the fluctuations of the economy. An engaging life-style. Adventure. Travel. And as much as $30,000 to $40,000 a year to start.

This year the Navy needs General Practitioners for the Flight Surgeon program, for Undersea Medicine, and as General Medical Officers. We also need specialists in Anesthesiology, Family Practice, Psychiatry, Internal Medicine, Neurology, Radiology, Pathology, and Pediatrics. If your interests lie in any of these clinical areas, and you'd like to get back to pure medicine, the Navy is for you. Get all the facts from your local Navy medical recruiter.

Fewer than 200 physicians are needed, so don't delay.

LT. DALE E. TODD
Medical Programs
404 458-6736

Navy Recruiting District, Atlanta
Presidential Park, Suite 101
3805 N.E. Expressway
Atlanta, Georgia 30340

Valley Psychiatric Hospital

P. O. BOX 21373 • SHALLOWFORD ROAD • CHATTANOOGA, TENNESSEE 37421
PHONE 615-894-4220

A 50-bed private acute intensive treatment facility with programs designed to treat psychological, alcoholic and drug abuse problems.

A full range of treatment modalities are utilized including individual and group psychotherapy, chemotherapy, and adjunctive and family therapies. Adjunctive therapy includes continuing education through home-bound teaching for school-aged adolescents, recreational, occupational and other supportive therapies. Group therapy is five days each week with individual therapy at least three days a week. Patients have six hours a day in scheduled therapeutic activities. Comprehensive outpatient services are available with outpatient group therapy sessions being held two nights each week.

Licensed by the State of Tennessee. A member of the Tennessee Hospital Association, the American Hospital Association and the National Association of Private Psychiatric Hospitals. **ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS.**

STAFF:

Psychiatry
D. Ross Campbell, M.D.
Henry Evans, M.D., Clinical Director
William C. Greer, M.D.
David V. MacNaughton, M.D.
John S. McDougal, M.D.
Robert T. Spaulding, M.D., F.A.P.A., Medical Director

Internal Medicine Consultant
Charles D. Kennedy, M.D.

Clinical Psychology
Thomas L. Cory, Ph.D.
Jerry C. Gilliland, Ph.D.
Ann Morris, M.S.
Bobby G. Rouse, Ph.D.
Roy Smith, Ph.D.

Adjunctive Therapy
Dan B. Page, M.Ed.

Administrator
Dennis P. Dobard

Her next attack of cystitis* may require

The Bactrim™ 3-system counterattack



*Due to susceptible organisms

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Bactrim™ DS Double Strength Tablets

ROCHE

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Please see reverse side for summary of product information.

ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets



Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Serving the General Insurance needs of the Medical Profession for over 50 years.

POTTER-HOLDEN & CO.

Agents of the St. Paul Insurance Companies

Gerry R. Holden, Jr.
C. Fred Roberts
John W. Fite

3390 Peachtree Rd., N.E.
Atlanta, Georgia 30326
262-7373

We welcome every opportunity to serve You.
Professional Liability—Umbrella—Property

YOUR Independent Insurance AGENT

HICKMAN DATSUN

ATLANTA HEADQUARTERS

5211 PEACHTREE INDUSTRIAL BLVD.
2 MILES INSIDE I-285
Phone 455-1122



DATSUN 280-Z

We're Specialists in
INTERPART ACCESSORIES,
KONI SHOCKS, SEMPERIT
RADIAL TIRES, AND...
We have the South's best service for the whole Datsun Line!



After specializing in the treatment of alcoholism and drug addiction for 17 years, we found . . .

if there are problems and there is drinking... drinking may be the only problem!

Willingway Hospital

BOX 508 STATESBORO, GA 30458 (912) 764-6236

Accredited by the Joint Commission on Accreditation of Hospitals


Kefzol® I.M./I.V.
cefazolin sodium
Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
NDC 0002-7014-01
AMPOULE No. 7014
Lilly
KEFZOL
STERILE
CEFAZOLIN
SODIUM
Equivalent to
10 Gm.
Cefazolin
Protect from Light
PHARMACY
BULK PACKAGE
NDC 0002-1497-01
AMPOULE No. 7497
KEFZOL
STERILE CEFAZOLIN
SODIUM
Equiv. to
500 mg.
Cefazolin
KEFZOL
1 Gm.
Lilly
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
700773

Presently there is a statewide shortage of 597 primary care physicians; by 1990, it is projected that the shortage will increase to 1,388

Primary Care Physician Manpower Study: Present and Projected Need

WELLS RILEY, M.D., *Jonesboro* and*
H. GORDON DAVIS JR., M.D., *Sylvester**

THIS STUDY WAS COMPILED by the Clinical Research Committee of the Georgia Academy of Family Physicians (GAFP) at the request of the GAFP Board of Directors and the Joint Advisory Board of Family Practice. Financial support for this study was provided by the GAFP Educational Foundation, Inc. and the School of Medicine, Medical College of Georgia.

The two primary purposes of the study were:

(1) To determine the number and distribution of primary care physicians in the State of Georgia, and (2) To determine present and project future needs for primary care physicians in the State of Georgia.

As with most physician manpower studies, this study is based on a physician-patient ratio (one physician per so many population). It has been recognized that adequate numbers of total physicians and/or adequate numbers of tertiary and secondary care physicians can exist at the same time that there is an inadequate number of primary physicians. Therefore, manpower estimates of primary care physicians must be separated from the whole.

Methodology

To document as nearly as possible the actual number of private-practice, primary care physicians in geographic subdivisions of the state (community, county, legislative district, health planning district), rosters of physicians (by year of birth and name) have been compiled. These rosters represent a distillation of information obtained from the State Licensing Board Physician Directory, the American Medical Association Physician Directory, and the Department of Human Resources Physician Directory. The data are based on the physician's own perception of the type of medicine he or she practices. The data were cross-referenced at the community and county level by selected physicians in the community and also by the county public health nurses.

Because of an inherent inability to measure precisely the proportion of time physicians in private practice spend in primary care activities, certain assumptions have been made:

1) Physicians designating their activity as solely general internal medicine, general pediatrics, general practice, family practice were considered full-time primary care physicians. (It is realized that these practitioners may also serve as referral physicians for secondary care. This is probably balanced by other, secondary and tertiary care, physicians in the community who provide similar amounts of primary care.)

2) Specialists who indicated that their first practice preference was one of the specialties listed in number one above and their second practice preference was a secondary or tertiary care subspecialty, or their practice preference was emergency room physicians, or their preference was general surgery with half their time spent in primary care were assumed to spend one-half of their time in primary care activities.

3) Specialists who considered their first practice preference to be a subspecialty (secondary or tertiary care) area were assumed to provide no

* Dr. Riley is Chairman of the Joint Advisory Board of Family Practice, Suite 612 Northside Tower, 6065 Roswell Rd., Atlanta, Ga. 30328; Dr. Davis is President of the Georgia Academy of Family Physicians, Suite 205, 11 Corporate Square, Atlanta, Ga. 30329. The Manpower Study was prepared by the Georgia Academy of Family Physicians' Committee on Clinical Research. Its members are: T. A. Sappington, M.D., Thomaston; William Nichols, M.D., Canton, and J. C. Calvert, M.D., Augusta.

primary care. (Obviously they do provide some primary care. It has been assumed that this would be balanced by #2 above and #4 below.)

4) Physicians, in #1 above, who for reasons of reduced workload because of age or illness, were considered to spend half of their time in primary care.

5) This study includes only those physicians in private practice. It does not consider physicians practicing institutional based medicine (mental health hospitals, schools of medicine, military, etc.).

6) When projecting future needs, those physicians over the age of 70 years were considered to have retired. (It is realized that many physicians continue to practice after age 70. It is assumed that the number continuing to practice will be balanced by those physicians under the age of 70 who for whatever reason are no longer in practice.)

The Manpower Study indicates that currently some 72% of Georgia counties are in need of additional primary care physicians; by 1990 some 91% will have such a deficiency

For the purposes of determining present and future needs, the physician-patient ratio of 1 : 2,500 was selected as a reasonable goal for the state. Similar studies done in other states and foreign countries have used, as an example, the following primary care physician-patient ratios: Denmark—1 : 2,200; England—1 : 2,700; Virginia—1 : 2,500. The ratio of 1 : 2,500 lies near the median of ratios established by western countries. In selecting the ratio of 1 : 2,500 it is realized that this is a starting point which may subsequently be amended.

State population projections were obtained from the Governor's office. In this study, for the year 1976, the 1975 population statistics were used.

Observations

Presently, of the 159 counties in Georgia, 117 or 72% need primary care physicians. It is projected that by 1980, 127 counties or 80% of the counties will have need for primary care physicians and by 1990, 145 or 91% of the counties will have need for primary care physicians (Table 1).

The average number of primary physicians each county is deficient is: 1976—5 physicians per county; 1980—6 physicians per county; 1990—9 physicians per county.

The projected number of physicians needed in deficient counties ranges between 0.5 and 56.5 physicians for 1976; 0.5 and 82 physicians for 1980; and 0.5 and 127 physicians for 1990.

In those counties where there is an excess of primary care physicians, the average number of excess physicians per county is: 1976—1 physician per county; 1980—1 physician per county; and 1990—1 physician per county.

Presently there is a statewide shortage of 597 primary care physicians (376 of whom are family physicians) who could provide medical care for 1,492,500 citizens (31% of the projected population of Georgia) (Table II).

In 1980 there is a projected shortage of 798 primary care physicians (503 family physicians) who, if available, could provide medical care for 1,995,000 citizens (39% of the projected population of Georgia).

In 1990 there is a projected shortage of 1,388 primary care physicians (877 family physicians) who, if available, could provide medical care for 3,470,000 citizens (59% of the projected population of Georgia).

If the proposed plan of the Joint Advisory Board of Family Practice is supported and funded beginning fiscal year 1977, approximately 550 family physicians would have graduated from three-year family practice residency training programs within the state by 1990. And they would have graduated from strategically located family practice residency training programs, increasing the probability of equitable geographic distribution of graduate family physicians. This coupled with the influx of primary care physicians into Georgia who have received their training in other states, as well as graduates from other primary care specialties within the state, will do much to meet the projected need for primary care physicians.

Presently more than 50% of the general and family physicians practicing primary care are 50 years of age or older.

It is important to note that the shortage of primary care physicians exists in both rural and urban settings.

Of the 4,161 physicians in private practice in

TABLE I

FAMILY/GENERAL PHYSICIAN DISTRIBUTION BY COUNTY

Year	None	Deficiency*	Excess or Adequate
1976	16	117	42
1980	20	127	32
1990	24	145	14

*** Includes those counties with no FP/GPs.**

TABLE II

PRIMARY CARE PHYSICIAN—PRESENT AND PROJECTED NEEDS FOR GEORGIA

	1975		1980		1990	
	PCP	FP	PCP	FP	PCP	FP
Number of Physicians	597	376	798	503	1388	877
Population Underserved	1.5 Mil.	0.9 Mil.	2.0 Mil.	1.3 Mil.	3.5 Mil.	2.2 Mil.
% Population Underserved	31%	20%	39%	25%	59%	37%

PCP = Primary Care Physician
FP = Family Physician
Mil. = Million Population

Georgia, 1,845 or 44% perceive themselves as spending one-half or more of their practice commitment in primary care. Of the 5,357 physicians in practice (private, institutional, etc.) in Georgia, 1,845 or 34% perceive themselves as spending one-half or more of their practice commitment in primary care.

In 1976, family/general physicians represented 69% (equivalent full-time physicians) or 63% (physicians perceiving themselves as spending one-half of their practice commitment or more in primary care) of the primary care physicians.

Conclusion

These data will hopefully assist:

1) *national and state bodies concerned with the logistics of providing health care.* On a state and nationwide basis, data such as these will allow for the definition of more specific goals in terms of numbers of physicians, types of physicians and geographic distribution of physicians.

2) *medical schools in planning new programs to produce primary care physicians.* Numbers and types of physicians produced, as well as the location of new programs, may be related specifically to the communities in need.

3) *physicians graduating from primary care training programs to locate their practices in areas of need in the state of Georgia.* Information demonstrating physician needs for individual communities has *not* been available to resident graduates in the past.

These figures indicate a severe shortage of primary care physicians in the state of Georgia. These shortages can be overcome. However, to do so will require a long-term commitment to significant funding of present and yet-to-be-developed primary care programs in the state of Georgia.

Recommendations

The Georgia Academy of Family Physicians and the Joint Advisory Board of Family Practice offer the following recommendations:

1) In order to provide an even more accurate estimate of primary care physician manpower, these or similar data should be applied to state population density statistics.

2) Though we believe the data provided in this document to be a reasonable assessment of primary care physicians manpower in the state of Georgia, it may prove beneficial to substantiate these findings through additional studies.

3) In order to meet the present and projected need for primary care physicians, serious consideration should be given by the state to the support and funding of the Joint Advisory Board of Family Practice's five-year plan to provide family physicians in areas of need throughout the state of Georgia.

RESOURCE DOCUMENTS

State of Georgia Area Designation Plan. Office of the Governor, George Busbee, May, 1975.

Family Physicians for Georgia—A Budget Proposal to the State of Georgia—Fiscal Years 1977-1982, Joint Advisory Board of Family Practice, October 1, 1976.

Georgia Physician Register, Division of Physical Health Office of Health Services Research and Statistics, Series 4, Volume 2, 1976.

The Shortage of Family Physicians—Report of the Virginia Advisory Legislative Council to the Governor and the General Assembly of Virginia, House of Document No. 7, Commonwealth of Virginia, 1972.

Register of Physicians Licenses in Georgia, Composite State Board of Medical Examiners, 1975 (plus updated documents through June 1976.)

American Medical Directory, American Medical Association, 1974.

Primary Physicians Manpower in Virginia—1972—Present Supply and Future Needs, Fitzhugh Mayo, M.D., November 20, 1972.

Recognition

The Clinical Research Committee of the Georgia Academy of Family Physicians is grateful for the assistance of Fredrick Minor (Medical Student), Ralph E. Williams (Medical Student), Mrs. Faye Forbes (Physician's Assistant), GAFP District Directors and Alternate Directors, County Public Health Nurses and others who were instrumental in gathering the data for this study.

INTERNIST/FAMILY PRACTITIONER: TIRED OF CITY TURMOIL?

Lake Elsinore, which is located only one hour south of Los Angeles and one hour north of San Diego needs you now. The area offers the best of living conditions in one of the most beautiful areas of California.

Due to population growth, we are now in need of two Internists and one Family Practice Physician. We offer excellent guaranteed income for first year with free office space and household move provided. If you want a busy practice away from city pressures, write with C.V. or call:

LAKEVIEW GENERAL HOSPITAL
Chris DiCicco, Administrator
P.O. Box 489
Lake Elsinore, California 92330
Telephone: (714) 674-1421

Ballard's

DISPENSING OPTICIANS

Quality and Service Since 1905

GUILD Rx OPTICIANS

Walter Ballard OPTICAL COMPANY

Main Office

480 PEACHTREE STREET
ATLANTA, GEORGIA
(404) 522-6178

W. W. ORR DOCTORS BUILDING
BAPTIST PROFESSIONAL BUILDING
SHEFFIELD MEMORIAL BUILDING

TEGA-SPAN CAPELLETS

FOR MORE ADVANCED NICOTINIC ACID THERAPY

Each capsule contains: . . . 400 mg of pure pelletized Nicotinic Acid

INDICATIONS: Tega-Span is indicated where reduction of serum cholesterol and total lipid levels in hypercholesteremia and hyperlipemia is desirable. It may also be useful in reducing xanthomatous tissue cholesterol deposits.

DOSAGE AND ADMINISTRATION: Usual dose is one or two capellets twice daily with or after meals. Since lower doses may control hyperlipidemia in some patients, the dosage should be individualized according to the effect on serum lipid levels. It is also to be noted that adverse reactions appear with great frequency early in therapy; in order to avoid these, it may be best to start the drug at low levels and increase dosage gradually.

Federal Law prohibits dispensing without a prescription

WE FEATURE ONE OF THE MOST COMPLETE LINE OF INJECTABLES IN THE SOUTHEAST AT THE VERY BEST PRICE, CONSISTENT WITH QUALITY.

ORTEGA PHARMACEUTICAL CO., INC.: JACKSONVILLE, FLORIDA 32205

A thought-provoking discussion of the implication of dietary fat alterations

Saturated Animal Fat, Plasma Cholesterol and Coronary Heart Disease

W. O. CASTER, Ph.D., ANNA V. A. RESURRECCION, Ph.D., *Athens

In modern society, a high fat diet is associated with high blood cholesterol levels and an elevated risk of coronary heart disease (CHD). This conclusion is based on numerous studies involving thousands of case histories drawn from populations throughout the world over the course of several decades. Ancel Keys has summarized the details of one of the largest of these studies which indicates that there is a high correlation ($r = 0.89$) between the saturated fat intake and serum cholesterol level, and a high correlation ($r = 0.84$) between saturated fat intake and the incidence of CHD.

Many public health writers go one step further and suggest that saturated animal fats be limited in, or excluded from, the American diet, and that polyunsaturated vegetable oils be substituted where possible. This suggestion, particularly the final part of it, constitutes one of the more controversial[2, 3] aspects of this topic. In order to understand this discussion, one must look into the background data relating to the nutrition of cholesterol, saturated fatty acids, polyunsaturated fatty acids (PUFA) and certain related materials.

Polyunsaturated Fatty Acids

In the epidemiological data reported by Keys,[1] PUFA is a substantially constant (4% of calories) portion of all common diets found throughout the world. It was difficult to find any population whose dietary contained less than 3% or more than 7% of its total energy in the form of linoleate. The monosaturated acid, oleate, provided a fairly constant percentage ($52 \pm 2\%$) of the total dietary fatty acid. The variable part of the dietary fat was to be found in the saturated fatty acids. Thus whenever the diets contained large amounts of fat there was a high proportion of saturated fatty acid (compared with the small but constant amount of PUFA), but when the diet contained little fat, the proportion of saturated fatty acids appeared low in comparison with PUFA. This means that, in these[1] data, the only diets to contain a large portion of the fat as PUFA were those diets which contained very little total fat.

There is one recent exception to this picture. Since the American food advertiser has learned the magic words "polyunsaturated" and "linoleate" some segments of the population in this country have adopted diets with PUFA levels far in excess of those previously experienced by any human population. The time period is yet too short to be certain of the health results associated with high PUFA diets. It is generally conceded that high PUFA diets can lower serum cholesterol levels by a small amount,[4] though some studies raise questions about this.[5, 6] Animal studies suggest other effects that are less desirable. High linoleate diets result in an increased deposition of cholesterol in liver and other tissues,[7] an increased tendency toward obesity,[7] and a possible increased susceptibility to certain types of cancer.[8]

* William O. Caster, Ph.D., is Professor of Nutrition and Anna V. A. Resurreccion is Visiting Postdoctoral Associate in Foods and Nutrition at the School of Home Economics, University of Georgia, Athens, Ga. 30602.

Cholesterol

The saturated animal fats in eggs, butter and meat fat are the major sources of cholesterol in the diet, and normally provide 0.5-1.0 g of cholesterol per day. Only about 10-30% of this (or 0.05-0.3 g) is absorbed by the gut, and is promptly mixed with another 1.5-2.0 g of cholesterol that is synthesized daily by the body. On the basis of this, one can anticipate that the cholesterol present in any reasonable diet will have relatively little effect on the daily cholesterol supply. Indeed, the presence of plant sterols, or other factors influencing the percentage absorption, may be equally important.

It can be argued that *any* increase is detrimental to the patient with hypercholesteremia, but this dietary effect is far too small to account for the original hypercholesteremia observed in the patient. Any attempt at rigorous exclusion of cholesterol from the diet may serve to remove high quality animal protein from the diet, with only a trivial effect on the size of the cholesterol pool in the body.

Saturated Fatty Acids

When one suggests that "saturated" animal fats are to be avoided, the implication is that some one or more saturated fatty acids have an adverse effect —but which ones? There are eight saturated fatty acids ranging from butyrate (C-4) to stearate (C-18) present in appreciable amount in different dietary fats—of which palmitate (C-16) and stearate (C-18) are by far the most common.

Most of the dietary studies with humans have employed natural fats and oils. These are complex mixtures and the interpretation of the results in terms of specific fatty acids is uncertain at best.

In work involving cocoa butter[9] it was deduced that stearate (C-18) did not increase serum cholesterol. Other work,[10] involving butter fat and palm oil, suggested that myristate (C-14) and, to a lesser extent, palmitate (C-16) were the active hypercholesteremic agents. However, in an addendum these same authors reported a repetition of this work with chemically pure myristate and palmitate, and failed to confirm these results. They concluded that "one might have to postulate that there are unknown factors" in butter fat and palm oil that are responsible for the observed effect.

Experimental work involving laboratory animals has made use of the chemically pure fatty acids required to resolve some of these questions more clearly. When all fatty acids from butyrate (C-4) through stearate (C-18) were incorporated into dietary fats in a statistically designed experiment,[11] it was found that only caproate (C-6) produced any increase in plasma cholesterol level. Caproate, present primarily in butter fat, coconut oil and palm oil, may yet prove to be the "unknown factor" postulated in the human work. No other saturated fatty acid produced an increase in plasma cholesterol

Other Factors

In a study of FAO data for 85 countries with 1.88 billion inhabitants, Perisse et al.[12] reported that the amount of fat in the diet was strongly correlated ($r = 0.84$) with annual income, and thus was an excellent index of all of those things that go with an affluent way of life. Among these one might point to a lack of exercise, "high-tension" work conditions and a diet high in sucrose ($r = 0.78$) and animal protein ($r = 0.77$) but lacking in crude fiber. All of these factors tend to occur together, and anything correlated with one will have a high correlation with all of the rest. This raises some obvious problems in the interpretation of epidemiological data relating to dietary fat intakes.

Conclusions

There is a high correlation between the amount of fat in the diet and both CHD and the plasma cholesterol level. This high correlation is seen for both the total amount of fat and the amount of saturated fat in the diet.

Emphasis has been placed on the "saturated animal fat." One should not be surprised, however, to find that even severe limitations on the amount of meat fat in the diet has little or no effect on the plasma cholesterol level in a given case. Somewhat better results might be anticipated if the person avoided excesses of butter fat, coconut oil, palm oil and egg fat—though the layman may not guess this from the use of the term "saturated animal fats."

Unless very substantial health effects are certain to result, one should be slow to advise severe dietary limitations that include the total elimination of high-quality animal protein from the diet. The linkage of health benefits to aberrant diets may make the patient more receptive to the siren songs of the food faddists.[13]

Strongly worded statements are to be found both for and against the practice of loading the diet with large amounts of polyunsaturated vegetable oils. Probably the more prudent method of increasing the polyunsaturated-to-saturated fatty acid ratio in a diet is by reducing the amount of saturated fatty acid through the simple device of reducing total fat. The elimination of "visible fat" in the diet, the broiling of meat and the use of low-fat cookery methods[14] can go far in this direction.

REFERENCES

1. Keys, A.: Coronary Heart Disease in Seven Countries. American Heart Association, Monograph No. 29; *Circulation*, 41(4), Supplement I:1 (April) 1970.
2. Reiser, R.: Saturated Fat in the Diet and Serum

Cholesterol Concentration: A Critical Examination of the Literature; *Am. J. Clin. Nutr.*, 26:524 (May) 1973.

3. Keys, A., Grande, R. and Anderson, J. T.: Bias and Misrepresentation Revisited: Perspective on Saturated Fat; *Am. J. Clin. Nutr.*, 27:188 (February) 1974.

4. Ahrens, E. H., Jr., Insull, W., Jr., Blomstrand, R., Hirsch, J., Tsaltas, T. T. and Petersen, M. L.: The Influence of Dietary Fats on Serum-Lipid Levels in Man; *Lancet*, 1: 943 (May) 1957.

5. Berkowitz, D.: Management of the Hyperlipidemic Patient; *Med. Clin. N. Am.*, 57:881 (July) 1973.

6. Bierenbaum, M. L., Fleischman, A. I., Green, D. P., Raichelson, R. I., Hayton, T., Watson, P. B. and Caldwell, A. B.: The Five Year Experience of Modified Fat Diets on Younger Men with Coronary Heart Disease. *Circulation*, 42:943 (November) 1970.

7. Caster, W. O., Resurreccion, A. V. and Bargmann, R. E.: Effect of Dietary Palmitate, Stearate, Oleate and Linoleate on Tissue Lipid and Systolic Blood Pressure in the Rat; *Internat. J. Vit. Nutr. Res.*, 46:480 (December) 1976.

8. Carrol, K. K.: Experimental Evidence of Dietary Factors and Hormone Dependent Cancers; *Cancer Res.*, 35: 3374 (November) 1975.

9. Keys, A. and Parlin, R. W.: Serum Cholesterol Response to Changes in Dietary Lipids; *Am. J. Clin. Nutr.*, 19: 175 (September) 1966.

10. Hegested, D. M., McGandy, R. B., Myers, S. M. and Stare, F. J.: Quantitative Effects of Dietary Fat on Serum Cholesterol in Man; *Am. J. Clin. Nutr.*, 17:281 (November) 1965.

11. Caster, W. O., Resurreccion, A. V., Cody, M., Andrews, J. W., Jr. and Bargmann, R. E.: Dietary Effects of the Esters of Butyric, Caproic, Caprylic, Capric, Lauric, Myristic, Palmitic and Stearic Acids on Food Intake, Weight Gain, Plasma Glucose and Tissue Lipid in the Male White Rat; *J. Nutr.*, 105:676 (June) 1975.

12. Perisse, V., Sizaret, F. and Francois, P.: The Effect of Income on the Structure of the Diet; *FAO Nutrition Newsletter*, 7:1 (July) 1969.

13. Rynearson, E. H.: Americans Love Hogwash; *Nutr. Rev.*, 32 (Supplement):1 (July) 1974.

14. Keys, A. and Keys, M.: How to Eat Well and Stay Well the Mediterranean Way. Doubleday, 1975, 488 pages.

National Health Insurance Blasted

A strong case against national health insurance was heard in Atlanta on October 11. The event was a seminar sponsored by The Congress of County Medical Societies, *Private Practice* Magazine, and the Private Medical Care Foundation. The meeting was one of 37 conducted nationwide and one of two held in Georgia (the other was in Augusta October 10). Some 200-300 physicians, medical students and medical assistants attended.

W. Daniel Jordan, M.D., Chairman of MAG's Committee on Medical Practice, was the moderator for a seven-member panel which included physicians from the United States, Canada, England and Australia. From Dr. Partridge of England, attendees learned of long waiting lists where patients wait three to four years for elective surgery. Doctors there receive $4.00 per year per patient—regardless of the number of visits or the seriousness of the illness, according to the British physician.

Dr. Mackey told of the less-well-known situation in Australia. When a nationalized system was put into effect there, many physicians refused to participate. They would not accept money from the government, but insisted their patients pay directly for medical services. At first, patients preferred the government's "free" service—until they discovered the long waiting and the inaccessibility of medical care. Now they are returning to the non-participating doctors. "We haven't turned around the system," Dr. Mackey said, "but we have stopped the advancement of socialized medicine."

In addition to discussing situations in other countries, the seminar participants also discussed strategies for combatting the U.S. government's move toward National Health Insurance. The group is against any NHI, including the one proposed by the AMA.

DICKEY-MANGHAM COMPANY
Since 1886

Complete Insurance Service

for

Physicians and Surgeons

Including Professional Liability with *Low* St. Paul Liability Rates as well as Automobile, Homeowners, Life and Disability

Phone

Glenn Lautzenhiser or Bill Grist

433-2132

2690 Cumberland Parkway

Atlanta, Georgia 30339

—ANNOUNCING—

The 41st Annual New Orleans Graduate Medical Assembly

"The High Risk Patient"

March 31-April 4, 1978

The Fairmont, New Orleans

Adolph A. Flores Jr., M.D.
President

Oliver H. Dabezies Jr., M.D., F.A.C.S.
Director of Program

ACCREDITATION: AMA Category I, Physicians' Recognition Award; American Academy of Family Practice—American College of Emergency Physicians; Category I

REGISTRATION FEES: Non-member Physicians—$200; Military—$100; Registered Nurses—$100; Students, Residents, Interns and Fellows—Complimentary.

- Presidential Reception
- Exhibitors' Champagne Reception
- Mississippi River Cruise
- Superdome Tour, Luncheon, Fashion Show for Guests

New Orleans Graduate Medical Assembly
Room 1538, Tulane Medical Center
1430 Tulane Ave.
New Orleans, La. 70112
(504) 525-9930

Practice Productivity Inc.

To be of genuine service to you is Practice Productivity's (PPI) reason for existence. PPI provides fine practice management assistance to many of your colleagues, helping each of them and their staff improve the quality of care given to patients.

Practice Productivity is a national management consulting firm for physicians. The principals are experienced consultants working in two significant areas:

1. We present workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. These workshops usually are endorsed by various specialty societies and state medical associations.
2. We provide in-depth consulting to physicians in private practice. Since we do not involve ourselves in the practice on a continuing basis, our objective is to visit the practice, expose practice problems, give proposed solutions, and set direction for the physicians to implement the needed changes. Our consulting experience covers nearly all medical specialties. References in your specialty are available upon request.

PPI's consistent message is "Sound business knowledge and procedures are essential to provide quality patient care." For further information on workshops or a consultative visit to your practice, contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

The management of pituitary tumors has changed considerably in recent years due mainly to significant improvements in the transsphenoidal microsurgical approach to the sella turcica

Transsphenoidal Microsurgery for Pituitary Tumors

GEORGE T. TINDALL, M.D., C. SCOTT MCLANAHAN, M.D.,
JAMES H. CHRISTY, M.D., *Atlanta**

As a result of advances in diagnostic and surgical techniques, the management of pituitary tumors has changed appreciably in recent years. Innovative developments and refinements in the transsphenoidal operation have resulted in a surgical procedure which has significant advantages over other approaches (i.e., craniotomy) to the pituitary. The principal advantages of the modernized transsphenoidal approach include the capability to remove completely the majority of pituitary tumors with preservation of the pituitary gland in a significant number of cases[2] and an extremely low operative mortality and morbidity.[5, 9, 16, 28, 29] Also, innovations in neuroradiological diagnosis, especially polytomography of the sella turcica and computerized tomography (CAT scan) serve to better define sellar and parasellar pathology[18] thus contributing significantly to the improved management of pituitary tumors.

The first successful transsphenoidal operation for a pituitary tumor was performed by Schloffer in 1907.[8] His approach was modified and used extensively by Hirsch and later, Cushing, who reported an operative mortality rate of only 5.5% in a total of 231 transsphenoidal operations.[15] However, technical drawbacks of the transsphenoidal operation such as inadequate visualization, resulted in poor exposure of many of these tumors, thereby accounting for a relatively high rate of recurrence in comparison with other approaches.[15] These discouraging recurrence rates together with the fact that modifications of craniotomy techniques were now making this approach safer resulted in a marked decline in usage of the transsphenoidal approach beginning around 1920.[15] Thus, the intracranial approach became and remained the operative procedure of choice until the mid 1960's when Guiot and Hardy rekindled interest in the transsphenoidal operative technique by adapting two major innovations —the operating microscope and televised fluoroscopy—to the operation.[13]

In the opinion of the authors, the advantages of the modern transsphenoidal microsurgical approach to the sella turcica clearly makes this operative approach the procedure of choice for the majority of pituitary tumors. In this publication we will discuss the pathological aspects, clinical features, and laboratory and radiological evaluations of pituitary tumors. In addition, the transsphenoidal operation as well as the results of this approach will be described.

Classification

Histologically, pituitary tumors are identified as chromophobe, acidophil, basophil and mixed adenomas. Functionally, these lesions can be divided into hormone-secreting and non-hormone-secreting tumors. Clinically, we have found that the functional classification is more practical. The hormone-secreting pituitary tumors include those lesions that produce an excess of growth hormone,[7] prolactin,[4, 30] adrenocorticotropin[22] and rarely, thyrotropin[12] or, even more rarely, a combination of hypersecretory states.[11, 30] Nelson's tumor is an ACTH producing pituitary tumor which develops in a small number of patients who have had bilateral adrenalectomy for treatment of Cushing's disease.[19] The great majority of pituitary tumors are histologically benign, slow-growing lesions.

* Dr. Tindall is Chief of Neurosurgery, Dr. McLanahan is a Resident in Neurosurgery and Dr. Christy is Professor of Medicine, Division of Endocrinology, at Emory University School of Medicine, Atlanta, Ga. 30322.

TABLE 1
CLINICAL EFFECTS OF HORMONE DEFICIENCIES AND EXCESSES

Hormone	Clinical Manifestations: Deficiency	Clinical Manifestations: Excess
Gonadotropin (LH & FSH)		
Adult male	Decreased libido and impotence; decrease in body hair, size of testicles and sperm count	No manifestation in adult
Prepubertal male	Failure to develop secondary sex characteristics	Precocious puberty in children
Adult female	Amenorrhea; infertility; decrease in breast tissue	No manifestation in adult
Prepubertal female	Failure to develop secondary sexual characteristics	Precocious puberty in children
Growth hormone (HGH)		
Adult	Usually no manifestation but occasionally fasting hypoglycemia	Acromegaly
Prepubertal	Retarded general growth and development. Dwarfism if occurs before age 3 years	Gigantism
Adrenocorticotropin	Adrenal insufficiency—generalized weakness, postural hypotension, etc.	Hyperadrenocorticism (Cushing's disease)
Thyrotropin	Hypothyroidism—cold intolerance; weight gain; sallow skin; slowed mentation	Thyrotoxiciosis—rare manifestation of chromophobe adenoma
Prolactin	No manifestation in male; in female, loss of lactating ability	Amenorrhea and galactorrhea in females (inconstant), rarely galactorrhea in males
Melanotropin	Loss of pigmentation	Hyperpigmentation
Vasopressin	Diabetes insipidus	Syndrome of inappropriate ADH (rarely caused by pituitary tumor)

Clinical Features

The clinical findings of pituitary tumor can be divided into 3 categories: local pressure, hormonal deficiencies and hormonal excesses. Local pressure effects are most commonly manifest by disturbances in visual acuity, visual field defects (usually bitemporal), headaches, cranial nerve palsies (usually oculomotor), and infrequently, signs of hypothalamic involvement. The most threatening problem is compression of the optic chiasm, a condition which can result ultimately in irreversible blindness. The clinical results of both deficiencies and excesses of the many hormones produced in the pituitary are summarized in Table 1.

Neurodiagnostic Evaluation

Routine skull roentgenograms and polytomography—Routine anteroposterior and lateral skull x-rays should be obtained in all patients with suspected pituitary tumors. The upper limits of normal for the sella turcica are as follows: AP diameter, 17 mm; depth, 14 mm; and width, 10 to 15 mm.[23] Anteroposterior and lateral polytomography of the sella turcica also should be obtained routinely. This important examination will show small areas of erosion and/or asymmetry of the sella turcica, alterations in the clinoid processes, as well as other important alterations that may not be discernible on routine skull x-rays.[26]

Pneumoencephalography—This test is useful in determining the extent of suprasellar extension of pituitary tumors. However, the CAT scan eventually may replace pneumoencephalography for this purpose. At present, the most important value of pneumoencephalography in evaluating patients with suspected pituitary tumors and enlarged sella turcica is to exclude the "empty sella syndrome." It is important that the physician recognize this condition as it is usually not a surgical problem.

Cerebral Angiography—Cerebral angiography is valuable in determining the extent of supra- or parasellar extension of pituitary tumors, but a more important use for angiography is to exclude the diagnosis of an intrasellar aneurysm. As experience with the CAT scan increases, it is likely that this diagnostic procedure also will replace angiography in determining the extent of extrasellar extension of pituitary tumors.

CAT Scan—While this important neuroradiologic diagnostic tool eventually will contribute importantly to the diagnostic evaluation of patients with pituitary tumors, the experience to date is not sufficient to define the exact role and importance of CAT scans in these lesions. Presently, CAT scans have

proven useful in identifying the size and extent of pituitary tumors that extended significantly above the diaphragm sella and laterally into the middle fossa.

Endocrinological Testing

Endocrinological testing should include an evaluation of the various pituitary-target organ axes as well as posterior lobe function. A recommended protocol for evaluation is shown in Table 2.

After obtaining fasting values, growth hormone (HGH) reserve is evaluated by determining serum HGH levels 120 and 150 minutes following the intramuscular administration of 1 mg glucagon.[10, 27] HGH reserve is considered normal if an increment of 5 ng/ml or greater is measured at either 120 or 150 minutes.

In patients with acromegaly (HGH secreting tumors), glucose suppression test should be performed. With the patient in a fasting state, simultaneous serum HGH and glucose values are obtained before and 30, 60, 120 and 180 minutes after administration of 100 G glucose orally. A serum fasting HGH greater than 10 ng/ml with less than 50% reduction at any time interval after glucose ingestion is considered abnormal and indicates the presence of autonomous secretion of HGH.[6]

Baseline serum prolactin (Prl) which is determined by radioimmunoassay is obtained with repeat determinations at 60, 120, 180 and 240 minutes after injection of 50 mg chloropromazine intramuscularly.[25] The fasting normal value ranges from 5 to 40 ng/ml. A less than twofold increase at any time after chloropromazine is considered to show loss of reserve if the baseline Prl value is low and loss of hypothalamic control if baseline is high. Because of their additional expense and sometimes questionable value, the metyrapone test and ACTH determination are not carried out routinely.

Indications for Surgery

As transsphenoidal microsurgery for pituitary tumors is safer and less troublesome to patients than intracranial operations, it is appropriate that the currently used indications for surgery are not as stringent as they were in the recent past. Currently, the specific indications for surgery in pituitary tumors are as follows:

1. **Tumors that produce excessive hormone secretion**

a. Growth-hormone (HGH) secreting tumors—Excessive secretion of HGH results in gigantism if the abnormal secretion begins prior to puberty, and acromegaly if after the onset of puberty. Both conditions result in appreciable body and facial disfigurements. In addition, acromegaly is associated with an increased incidence of arteriosclerotic heart disease[20] and arthritis, and the average life span of patients with untreated or partially treated acromegaly is lower than normal individuals.[3] In the majority, transsphenoidal microsurgery accomplishes complete tumor removal with sparing of the normal pituitary gland.

b. Tumors associated with elevated prolactin levels—Typically, these tumors are associated with oligomenorrhea, amenorrhea, or the amenorrhea-galactorrhea syndrome and are seen in young adult women. The diagnosis is confirmed by the demonstration of abnormally high serum prolactin levels (>40 ng/ml) and/or an inappropriate response in serial prolactin levels following chloropromazine stimulation. The results of transsphenoidal microsurgical removal of these tumors are good. The patients cease lactating in a few days and resume a normal menstrual pattern within 2 to 3 months.

2. **Tumors that produce hormonal deficiencies**—Tumors, usually chromophobe adenomas, that do not secrete hormone(s) gradually increase in size and eventually damage the pituitary gland, thus resulting in varying degrees of hypopituitarism. Thus, impairment in pituitary endocrine function constitutes an important indication for surgery in pituitary tumors.

3. **Tumors that produce symptoms of local compression**—Surgery should be carried out in pituitary tumors that cause compression of neighboring structures. The optic pathways are frequently involved with resulting loss of acuity and/or visual fields. For instance, in 106 patients with chromophobe adenomas, Ray and Patterson found that visual disturbances constituted the initial symptoms in 38% and that by the time the patients came to surgery, visual symptoms were present in 93% of the group.[2]

Surgical Technique

The transsphenoidal microsurgical approach to the pituitary, which was illustrated in a previous report in this *Journal*,[24] is performed using general anesthesia. The upper lip is retracted and an incision made in the gingival mucosa. The soft tissues are separated from the maxilla and the mucosa of the nasal passage is exposed. After developing a submucosal dissection plane along each side of the nasal septum, the lower portion of the septum is excised and the anterior wall of the sphenoid sinus (vomer) is removed. Upon entering the sphenoid sinus, the surgeon identifies the exact limits of the floor of the sella turcica using televised fluoroscopy. The operating microscope is then brought into the surgical field and the remainder of the operation is performed using magnification.

Pituitary tumors usually enlarge and often erode the floor of the sella turcica and frequently tumor

TABLE 2

ENDOCRINOLOGICAL TESTING PITUITARY TUMORS

Anterior Pituitary Function Tests

Pituitary-Gonad Axis	**Pituitary-Adrenal Axis**
Follicular stimulating hormone—FSH	Serum cortisol
Luteinizing hormone—LH	24 hour urinary ketosteroid—17 KS
Estradiol (females)	24 hour urinary hydroxycorticosteroid—17 OHCS
Testosterone (males)	
Pituitary-Thyroid Axis	**Growth Hormone Reserve**
Thyroid stimulating hormone—TSH	**Growth Hormone Suppression**
Total thyroxine—T4	
Free thyroxine—FT4	**Prolactin Reserve**

Posterior Pituitary Function Tests

Simultaneous Serum and Urine Osmolalities
After 8-12 hour period of water deprivation

TABLE 3

SYMPTOMS IN 55 PATIENTS WITH PITUITARY TUMORS

Symptom	Presenting	Present
Headache	13	27
Loss of vision	15	22
Diplopia (persistent or episodic)	1	6
Change in habitus	10	16
Loss in libido	2	6
Cold intolerance	0	4
Amenorrhea (with or without galactorrhea)	9	15

extrudes in the operative wound upon removing the floor of the sella and opening the dura mater. The exposure of the sella turcica provided by the transsphenoidal approach with the operating microscope is excellent and enables the surgeon to remove tumor and spare the pituitary gland (provided the gland has not already been destroyed by the tumor). Frequently, the pituitary gland is compressed and flattened against the dorsum sella or diaphragm sella by the tumor. However, despite marked compression, the pituitary gland will continue to function normally in the majority of cases. Following tumor removal, absolute alcohol is applied to the tumor bed for a period of two minutes. It is important that alcohol is used only when the diaphragm sella-tumor capsule is intact thus forming a barrier between the subarachnoid space and tumor site.

Following completion of tumor removal adipose tissue taken from the abdominal wall is inserted into the tumor bed in order to prevent prolapse of the optic chiasm into the sella turcica. Closure of the wound is simple and involves three catgut sutures in the gingival mucosa. Soft airway tubes are inserted into each nostril in order to reapproximate the nasal mucosa. The patient is then allowed to recover from anesthesia.

Post-operative management of patients undergoing transsphenoidal microsurgery for pituitary tumor is relatively simple. They recover from anesthesia quickly and do not experience problems such as cerebral edema, which frequently follows craniotomy.

Case Material

Our experience is based on 55 patients with pituitary tumors treated at Emory University Hospital during the period from August, 1973 through September, 1976. There were 25 men and 30 women with ages ranging from 16 to 82 years. A transsphenoidal microsurgical operative approach was used in each case and a total of 56 operations were performed in these 55 patients.

Histologically, the tumor was a chromophobe adenoma in 40 cases, one of which showed malignant features; an eosinophilic adenoma in 13 cases; a mixed adenoma in one case, and a previously irradiated adenoma that could not be classified.

All patients underwent a formal protocol of testing for pituitary function (Table 2) prior to and ten days after surgery. The tests were designed to yield maximal information from the least study that would allow accurate assessment of general pituitary and pituitary-target organ function.

The symptoms, including the presenting symptom recorded in these patients are listed in Table 3. The most common complaint was headache, which was present in 27, or 49%, of the 55 patients. Next in frequency were visual symptoms which occurred in 22, or 40% of the cases.

Results

The results following transsphenoidal surgery in our series of 55 cases will be discussed in terms of visual improvement, completeness of tumor removal, preserved pituitary function, return of abnormal levels of hormone secretion to normal values, and complications.

1. Improvement in Vision—In 20 patients with pre-operative impairment in visual fields, significant improvement, usually during the first week after surgery, was obtained in 15 and slight improvement or no change occurred in five patients. In 15 patients with impairment in visual acuity, 11 were significantly improved and four showed either slight improvement or no change. In no case in our series did surgery create a visual field or acuity defect where none was present pre-operatively.

2. Completeness of Tumor Removal—Gross total tumor removal was accomplished in 44 patients and

TABLE 4
IMPROVEMENT IN SYMPTOMS FOLLOWING TRANSSPHENOIDAL SURGERY

Symptoms and No. of Patients	Number of Patients Relieved	Significantly Improved	Somewhat Improved or Stable	Persistent or Worse
Headache (22)	20		2	
Loss of vision (19)		16	4	
Diplopia (6)	6			
Change in habitus (14)		13	1	
Loss of libido (4)				4
Cold intolerance (2)	2			
Amenorrhea (9)	5			4

subtotal removal in 11 cases. Gross total removal means that all tumor tissue as visualized with the operating microscope was excised. Of the 11 cases with subtotal removal, the residual tumor was very small in five cases.

One patient whose growth hormone level failed to return to normal following surgery is considered a treatment failure for a rate of 7% for eosinophilic adenomas. Of the chromophobe adenomas, one demonstrated malignant features and the patient received post-operative radiation therapy. However, he subsequently had recurrence of symptoms about one year post-operatively, culminating in his death and is also counted as a treatment failure. Another patient with a chromophobe adenoma, who had a subtotal removal and was treated post-operatively with radiation, died 19 months following surgery, probably of acute adrenal failure. However, the autopsy showed tumor in the temporal lobe. He is also considered a treatment failure. Thus, the treatment failure rate in our series to date is three cases, or 5% of 55 total cases.

3. Preservation of Endocrine Function—The pituitary gland was identified and spared in 39 cases, not visualized in 13, and purposely removed in three cases. Because of their relatively smaller size, it was easier to accomplish both total tumor removal and sparing of the pituitary gland in cases of secreting tumors, principally because these patients seek medical attention earlier than patients with non-secreting tumors. However, pre- and post-operative endocrinologic evaluation provides a more accurate assessment than gross observations of the status of pituitary function in these patients. Pre- and post-operative thyroid function was measured in 33 patients. Of this number, pre-operative thyroid function was normal in 28 and low in five patients. Post-operatively, 23 of the 28 patients maintained normal thyroid function while five patients were found to have low post-operative values. Interestingly, of five patients with low pre-operative thyroid values, three patients returned to normal values post-operatively while two patients maintained low thyroid values.

In 15 patients with pre-operative normal gonadotropin function, values post-operatively remained normal in 14 patients and were low in one. Of 17 patients with low gonadotropin values pre-operatively, the values returned to normal in three and remained low in 14 patients.

Normal pre-operative adrenal function in 29 patients was maintained in 28 patients post-operatively, while only one of the 29 showed impaired adrenal function following surgery. Of two patients with low pre-operative adrenal function, one returned to normal value and one remained low.

4. Return of Abnormal Levels of Hormone Secretion to Normal Values—Growth hormone elevations (acromegaly)—Twelve patients with acromegaly had elevated levels of HGH ranging from 19 to 153 ng/ml. One additional patient with acromegaly had a fasting HGH value of 6.8 ng/ml but the value could not be suppressed with administration of glucose. Post-operatively, the values for HGH returned to normal in 12 of 13 patients. One patient continued to maintain high values despite removal of all intrasellar tissue at a second transsphenoidal operation.

Elevated Prolactin Values—Following surgery, the elevated levels of prolactin returned to normal in 15 of 19 patients. Although still elevated in four patients, the values were nevertheless below the pre-operative values. The persistent elevation in prolactin in these four patients does not necessarily imply the presence of residual tumor tissue in each case. A more plausible explanation is that either the tumor and/or surgery induced pituitary stalk damage sufficient to interfere with the normal flow of prolactin-inhibiting factor (PIF) from the hypothalamus.

5. Improvement in Symptoms—Relatively long term results were available for review in 41 of the 55 cases with follow-up periods ranging from four to 38 months. These data are shown in Table 4. Following surgery, headache was relieved in 20 and

improved in two patients. Subjective visual impairment, present in 20 was significantly improved in 16 and slightly improved in four patients. Altered body features was a complaint among acromegalic patients. This symptom was improved in 12 of 13 patients. The improvement usually consisted of a decrease in ring or shoe size or both.

Complications

Immediate post-operative complications were relatively few and benign in nature. There were no deaths and no patient developed meningitis or cerebrospinal fluid rhinorrhea. Transient diabetes insipidus occurred in 16 patients post-operatively requiring one or more doses of pitressin tannate in oil. Five of these patients were discharged on clofibrate, a drug which has been found to be effective in treating partial diabetes insipidus.[17] Two patients have subsequently been able to discontinue the drug.

Discussion

The present series of cases emphasizes many of the advantages of the modern transsphenoidal microsurgical approach to pituitary tumors over other operative approaches such as craniotomy. Chief among these advantages as indicated by our experiences and by the reports in the literature[2, 5, 8, 9, 14–16, 28, 29] has been a low incidence of complications and an extremely low and acceptable mortality rate associated with the operation. In our series of cases, there were no deaths and the complications were relatively benign and not disabling. The transient nature of diabetes insipidus in most of the patients who developed this problem was probably related to edema of the pituitary stalk incident to operative manipulation. The rare occurrence of cerebrospinal fluid rhinorrhea reported in the literature and absent from the present series is related to the fact that pituitary tumors are separated from the subarachnoid space by the diaphragm sella-pseudocapsule of the tumor. Thus, a neurosurgeon experienced with the transsphenoidal approach can remove all gross appearing tumor and spare this covering structure thus preventing a cerebrospinal fluid leak.

Another significant advantage of transsphenoidal surgery over other operative approaches is that gross total removal of the majority of tumors, even those lesions that extend significantly above the upper limits of the sella turcica can be accomplished with preservation of the pituitary gland in the majority of the cases. Not only can pituitary function be maintained, but as shown in the present study, certain hormonal functions may be restored following successful removal of the tumor by the transsphenoidal approach. In the authors' opinion, the ability to remove tumor and spare normal pituitary tissue with an operation that carries a low incidence of complications and rare mortality constitutes a major advance in pituitary tumor surgery.

The results of transsphenoidal surgery in terms of decompressing the optic chiasm and pathways and restoring visual fields and acuities has also been impressive and indicate that this operative approach is appropriate in patients who are experiencing deterioration in vision as a result of compression of the visual pathways from pituitary tumors. The beneficial effects on visual loss accomplished by transsphenoidal microsurgery are similar to the best reported results following transcranial operations. For instance, our results compare favorably with those reported by Ray and Patterson.[21] In 106 patients treated by craniotomy, they obtained significant improvement in 80% and in approximately 50% normal vision was restored. There was no change in 18% and in 1.9% (two patients) there was measurable loss of vision.

Transsphenoidal microsurgery effectively treats pituitary tumors that secrete excessive quantities of hormones. In these cases, tumor excision is usually followed by a rapid reduction of the excessive hormone secretions to normal levels. Sparing of the normal pituitary gland is also usually possible in these cases. The transsphenoidal microsurgical approach has been especially beneficial in the treatment of acromegaly as indicated by the reports in the literature and the results of the present study.[1, 2] Proton beam therapy has also been used in pituitary tumors associated with acromegaly and until recently was regarded as probably the appropriate modality of therapy. However, the major objection to irradiation therapy of any type, including proton beam, is the fact that there is a long delay, i.e., 12 to 18 months, from the time treatment is begun before beneficial lowering of HGH occurs. When using irradiation as a method for treating pituitary tumors, there is also the potential danger of producing damage to the normal pituitary gland and important adjacent structures. This is especially true when high energy, proton beam therapy is used. Also, very expensive equipment accessible at only a few institutions is required and the method is not suitable for tumors that have suprasellar or parasellar extensions.

The value of routine post-operative irradiation following transsphenoidal microsurgical "gross total" removal of a pituitary tumor is uncertain. In those cases where obvious gross tumor is left behind, it is our opinion that routine irradiation should be used. However, whenever all gross appearing tumor tissue is removed, then it seems appropriate not to use post-operative irradiation. Particularly in certain cases, such as a small hypersecreting tumor where

all abnormal tissue is removed and the tumor bed treated with absolute alcohol, it would seem ill-advised to treat these patients with irradiation. Obviously, long-term follow-up will be required to determine the best course ultimately to follow.

The role of CAT scans in the diagnostic evaluation of patients with pituitary tumors is yet to be defined. It is certain to play an important role, particularly in defining the extent of supra- and para-sellar extension of these lesions and may well replace more conventional diagnostic methods, i.e., pneumoencephalography and cerebral angiography, in this respect. The "empty sella syndrome" remains a diagnostic problem and presently, the major role of pneumoencephalography is in diagnosis of this condition. Hopefully, continued refinements in CAT scanning techniques ultimately will allow the diagnosis of this entity with some certainty.

REFERENCES

1. Atkinson, R. L., Becker, D. P., Martins, A. N. et al.: Acromegaly—Treatment by Transsphenoidal Microsurgery; *JAMA,* 233:1279-1283, 1975.
2. Becker, D. P., Atkinson, R., Sakalas, R. et al.: Transsphenoidal Microsurgery for Acromegaly; *Confin. Neurol.,* 36:101-105, 1974.
3. Bishop, P.: Cited by Lawrence, et al. in *Acta Radiol.,* 58:337, 1962.
4. Child, D. F., Nader, S., Mashiter, K. et al.: Prolactin Studies in "Functionless" Pituitary Tumors; *Brit. Med. J.,* 606-609, 1975.
5. Ciric, I. S. and Tarkington, J.: Transsphenoidal Microsurgery; *Surg. Neurol.,* 2:207-212, 1974.
6. Cryer, P. E. and Daughaday, W. H.: Regulation of Growth Hormone Secretion in Acromegaly; *J. Clin. Endocr.,* 29:386-393, 1969.
7. Cryer, P. E., Daughaday, W. H., Coxe, W. S. and Avioli, L. V.: Diagnosis and Therapy of Acromegaly; *Arch. Intern. Med.,* 135:338-343, 1975.
8. Cushing, H.: Surgical Experiences With Pituitary Disorders; *JAMA,* 63:1515-1525, 1914.
9. Dalton, G.: Transsphenoidal Hypophysectomy for Pituitary Tumors; *Proc. Roy. Soc. Med.,* 67:885-889, 1974.
10. Eddy, R. L., Gilliland, P. F., Ibarra, J. D. et al.: Human Growth Hormone Release: Comparison of Provocative Test Procedures; *Am. J. Med.,* 56:179-185, 1974.
11. Franks, S., Jacobs, H. S. and Nabarro, J. D.: Prolactin Concentrations in Patients With Acromegaly, Clinical Significance and Response to Surgery; *Clin. Endocr.* (Oxford), 5:63-69, 1976.
12. Hamilton, C. R., Adams, L. C. and Maloaf, F.: Hyperthyroidism Due to a Thyrotropic-Producing Pituitary Chromophobe Adenoma; *New Eng. J. Med.,* 283:1077-1070, 1970.
13. Hardy, J.: Transsphenoidal Microsurgery of the Normal and Pathological Pituitary; *Clin. Neurosurg.,* 16:185-217, 1968.
14. Hardy, J. and Wigser, S. M.: Transsphenoidal Surgery of Pituitary Fossa Tumors With Televised Radiofluoroscopic Control; *J. Neurosurg.,* 23:612-620, 1965.
15. Henderson, W. R.: Pituitary Adenomata, Follow-up Study of Surgical Results in 338 Cases (Dr. Harvey Cushing's series); *Brit. J. Surg.,* 26:811-921, 1939.
16. Hudson, W. R. and Kenan, P. D.: Transsphenoidal Management of Pituitary Adenomas and Other Selected Lesions of the Sella Turcica; *Laryngoscope,* 84:1159-1169, 1974.
17. Moses, A. M., Howanitz, J. and van Gemert, M.: Clofibrate-Induced Antidiuresis; *J. Clin. Invest.,* 52:535-542, 1973.
18. Naidich, T. P., Pinto, R. S., Kushner, M. J. et al.: Evaluation of Sellar and Parasellar Masses by Computed Tomography; *Radiology,* 120:91-100, 1976.
19. Nelson, D. H., Meakin, J. W. and Thorn, G. W.: ACTH-Producing Pituitary Tumors Following Adrenalectomy for Cushing's Syndrome; *Ann. Intern. Med.,* 52:560-569, 1960.
20. Pepine, C. J. and Aloia, J.: Heart Muscle Disease in Acromegaly; *Am. J. Med.,* 48:530-534, 1970.
21. Ray, B. S. and Patterson, R. H.: Surgical Experience With Chromophobe Adenomas of the Pituitary Gland; *J. Neurosurg,* 34:726-729, 1971.
22. Samaan, N. A., Leavens, M. E. and Jesse, R. H.: Pituitary Tumors, Recent Advances in Diagnosis and Management; *Texas Med.,* 70:55-62, 1974.
23. Taveras, J. and Wood, E.: *Diagnostic Neuroradiology.* Baltimore, The Williams and Wilkins Co., 1964, 102.
24. Tindall, G. T., Ambrose, S. S. and Christy, J. H.: Hypophysectomy in the Treatment of Disseminated Carcinoma of the Breast and Prostate Gland; *JMAG,* 64:69-74, 1975.
25. Tolis, G., Goldstein, M. and Friesen, H. G.: Functional Evaluation of Prolactin Secretion in Patients With Hypothalamic-Pituitary Disorders; *J. Clin. Invest.,* 52:783-788, 1973.
26. Vezina, J. L. and Sutton, T. J.: Prolactin-Secreting Pituitary Microadenomas Roentgenologic Diagnosis; *Am. J. Roentgen.,* 120:46-53, 1974.
27. Wieland, R. G., Hallberg, N. C. and Zorn, E.: Growth Hormone Response to Intramuscular Glucagon; *J. Clin. Endocr.,* 37:329-330, 1973.
28. Williams, R. A.: Transsphenoidal Hypophysectomy for Acromegaly; *Proc. Roy. Soc. Med.,* 67:881-884, 1974.
29. Wilson, C. B., Rand, R. W. and Grollmus, J. M. et al.: Surgical Experience With a Microscopic Transsphenoidal Approach to Pituitary Tumors and Non-Neoplastic Parasellar Conditions; *Calif. Med.,* 117:1-9, 1972.
30. Zimmerman, E. A., Defendini, R. and Frantz, A. G.: Prolactin and Growth Hormone in Patients With Pituitary Adenomas: A Correlative Study of Hormone in Tumor and Plasma by Immunoperoxidase Technique and Radioimmunoassay; *J. Clin. Endocr.,* 38:577-585, 1974.

Eager and Simpson

Since 1919

☐ Hospital Fittings of Orthopedic Supports

☐ Breast Prosthesis—Foundation Garments

82 Ivy Street, N.E.
Atlanta, Georgia 30303
(404) 522-4972

don't look in the yellow pages...

Many of the goods and services you need are advertised in your Journal. *Below is a classified listing of companies who have advertised a minimum of three times in the past six months or who will be advertising a minimum of three times in the next six months. These advertisers make the* Journal *possible. Please help us show them our appreciation by taking a few minutes to let them know you are checking them first.*

ASSOCIATIONS

Pharmaceutical Manufacturers Association
Weight Watchers of Greater Atlanta

AUTOMOBILE DEALERS

Capital Automobile—*Cadillac*
Chris Motors—BMW
FAF Motorcars, Inc.—*Ferrari*
First Georgia Leasing—all makes
Franz Blam Racing—Imports
Global Imports—BMW
Hickman Datsun

AVIATION

Epps Air Service
Executive Aviation Corporation

BOOK PUBLISHERS

The Harrison Company

COLLECTION AGENCIES

Creditor's Mercantile

CME BOOKKEEPING

Physician's Registry

DATA PROCESSING SERVICES

Data Med Health Systems
Systemedics of Georgia

FINANCIAL ASSISTANCE

Hosmer and Associates

HEARING AIDS

Beltone Electronics

HOTELS

Omni International, *Atlanta*
Terrace Garden Inn, *Atlanta*

INSURANCE

Blue Cross and Blue Shield of Georgia/Atlanta
Dickey-Mangham Company
John Lusk
Potter-Holden & Company

INTERIOR DESIGN

River Interiors

INVESTMENT COUNSELORS

Consolidated Planning Corporation
Preferred Partnerships, Inc.

MANAGEMENT CONSULTANTS

Practice Productivity, Inc.
Family Health Care, Inc.

MEETINGS

New Orleans Graduate Medical Assembly

MILITARY

Georgia Army National Guard
U.S. Air Force
U.S. Navy

OFFICE FURNISHINGS

North DeKalb Office Supply

OPTICIANS

Walter Ballard

OXYGEN SUPPLIERS

Medical Oxygen Services, Inc.

PHARMACEUTICAL COMPANIES

Armour Pharmaceuticals
Burroughs Wellcome Co.
Dorsey Laboratories
Eli Lilly and Company
Merck Sharp & Dohme
Ortega Pharmaceuticals
Pennwalt
A. H. Robins Company
Roche Laboratories
Roerig
Smith Kline & French
Squibb & Sons, Inc.
The Upjohn Company
Warner Chilcott

PSYCHIATRIC HOSPITALS/ ADDICTION TREATMENT FACILITIES

Brawner Hospital, Inc.
Hill Crest
Metropolitan Psychiatric Center
Peachford Hospital
Peachtree and Parkwood Hospitals
Valley Psychiatric Hospital
Wellspring
Willingway Hospital

REAL ESTATE

Duluth Professional Building
Lake Arrowhead
Scott Hudgens Properties

RESTAURANTS

Bugatti
The French Restaurant
Max'
Mimi's

SOFT DRINK MANUFACTURERS

Coca-Cola Company

SURGICAL/MEDICAL SUPPLIES

Eager and Simpson
Estes Surgical Supplies
The Ostomy Center

SWIMMING POOLS

Aqua-Rama

check your JOURNAL first.

editorials
editorials
editorials

MAG 1977

AS WE COME TO THE END of 1977, it seems appropriate to look back over the year just past and reflect on our MAG activities.

Heartening news for all of us is the steady and healthy growth of our Association. The concept of unified membership, rather than proving to be a divisive influence, would appear to have been a stimulus for growth. In 1976 we had a total of 3,809 dues-paying MAG members, with 3,011 AMA members. Through 1977, we have grown to a membership of 4,054 for the MAG, with AMA members totaling 3,076.

During the 1977 Georgia General Assembly, in excess of 100 bills were introduced dealing with the health care delivery system. MAG took an active part in testifying and communicating to the Georgia legislators our position on 67 of these issues. Nothing passed which MAG opposed.

The MAG Legislative Committee once again sponsored a Legislative Seminar at Pine Isle in which some 140 physicians and their wives participated and were part of the classroom audience of 20 Georgia state legislators. This seminar was designed for the education of MAG members with regard to the legislative process and to point out why Georgia physicians should be members of a state organization. They also stressed how their organization and they as individuals can best have their voice heard in the political arena.

Our Disabled Doctors' Program, authorized by the Board of Directors in September 1975, has shifted into high gear during 1977. So far, out of 64 disabled doctors contacted and verified, 47 have entered the program. Of this number, 29 have been returned to practice. This averages more than one doctor per month returning to active practice. Eighteen physicians are currently undergoing rehabilitation.

We point with some pride to the fact that the May issue of our *Journal*, featuring medical cost containment, received national recognition. The AMA featured the issue in a press release distributed to all state associations. Two other state journals reprinted papers from our issue. Letters and requests for reprints were received from five states and from several county societies. Some 300 reprints were distributed by request.

A real highlight of 1977 for the MAG was the election of Harrison Rogers as Vice-speaker of the House of Delegates at the annual meeting of the American Medical Association in San Francisco. We are certain that he will be a credit to the MAG in his new position of leadership.

The activation of the Speakers Bureaus in Columbus and over other parts of the state are effectively bringing the truth about medical care to the citizens of our state. Proliferation of these groups has been encouraged by the MAG.

Sponsorship of Health Care Forums in Atlanta and other parts of the state has met with enthusiastic acceptance. Their continuation and growth are anticipated. Such programs have been advocated editorially in the *Journal* and are vigorously promoted by the Education Committee.

In October, at a Regional Hearing in Atlanta sponsored by the Department

of Health, Education and Welfare, our president Robert Perry spoke eloquently in our behalf. He testified on the dangers inherent in national health insurance.

Georgia, through the efforts of the MAG was chosen by the AMA in early 1976 as one of six pilot states for the purpose of developing and implementing plans to improve health care in jails. Already, through a very busy committee, the MAG has been active in assisting five pilot jails around the state in meeting minimal standards of health care for their inmates. A workshop has been given for 24 jailers on techniques of receiving-screening of inmates. Many more instructive workshops and speakers groups are planned in an effort to improve health care of this frequently neglected segment of our society.

Magnet '77 in October focused on cost control in medical practices. This annual program is designed not only for physicians but for business managers, medical assistants and others interested in practical answers for effective operation of the business aspects of a medical practice. This year a total of 104 participants were registered. Over 90% of the participants rated the program conducted by a professional firm as valuable and informative.

Our 1977 MAG Scientific Assembly in November included accredited continuing medical education programs in 16 specialties as well as an interdisciplinary workshop and alumni events. This year a record number of MAG members attended. Highlighting the assembly was the annual MAG luncheon and Abner W. Calhoun Lecture delivered by Timothy Johnson, noted columnist on health and TV's "House Call" doctor. Our special guests included the governor's wife and a number of top civic and business leaders.

Because of space limitations, many worthwhile activities of your Association have not been cited.

Probably the greatest satisfaction of the year just past with all of its adversity, has been a deep feeling that we are becoming more united, the more we are challenged by our detractors from outside the profession. If indeed attacks from outside our profession can stimulate us to unite and put our own house in order, then we may look forward to 1978 with healthy anticipation.

Happy New Year!

Edgar Woody Jr., M.D.
Editor

Access to Health Care Committee at Work

THE MEDICAL ASSOCIATION of Georgia has always been concerned about the ability of people to obtain health care when it is needed. As more and more communities became underserved by physicians and the proportion of generalists to specialists diminished, increasing pleas for help for areas of critical medical shortages were heard over the state. One response of the MAG was to create a Committee on Access to Health Care charged with the responsibility of investigating the problems. It was found that there was not much data forthcoming, so the physicians of the state were solicited for their views. Other surveys were forthcoming, but it was generally conceded that not every county or community needed or could attract young medical practitioners. It was also evident that not enough primary care physicians, including family practitioners, were available to meet the demand. Family practice residency training has been supported by the MAG and the Georgia Academy of Family Physicians and the State Assembly responded by creating the Joint Advisory Board which attempts to address the problem.

Next the Committee on Access to Health Care felt that the MAG should up-

date and keep current a listing of physicians seeking practice localities and communities seeking new doctors.

The Committee also began about a year ago working with the Southeastern Institute for Community Health, Inc., and its president, M. J. Duttera Jr., M.D. of La Grange, to plan a Physician's Recruitment Conference for communities in Alabama and Georgia and a Pre-Practice Seminar for physicians getting ready to practice. The location selected was Callaway Gardens and the time October 20-23, 1977. Rural communities in the two states were invited to send representatives and set up booths extolling the virtues of their localities. Family practice and other residents over the two states were invited so that they could get information about practice and also meet the representatives of all the interested areas.

Forty-one communities sent 170 representatives and there were 41 M.D.s with 27 spouses and six guests.

There was a fee charged for each booth. The physicians were charged a $25.00 registration fee but the Institute underwrote the two nights lodging and meals for them and their spouses.

In conclusion, there is belief that the entire endeavor was a success because it gave communities and physicians a chance to get acquainted. It is hoped that this can be repeated in 1978, and if it continues to be well-received, might even become an annual event co-sponsored by the Southeastern Institute and the MAG. It is also hoped that a similar Job Fair might be set up for medical students in Georgia in order to create interest before the students are committed to a practice location.

M. C. Adair, M.D.
Chairman
MAG Committee on Access to Health Care

TEST DRIVE THE LUXURY COUPE THAT'S AS EXCITING TO DRIVE AS IT IS TO SIT IN.

Get our quote on your next lease. No leasing company can beat our rates. Nobody can beat our service. Lease or purchase your car from us and be assured of "no hassle" service. Our customers come first.

Leasing and Sales.





GLOBAL IMPORTS

225 PHARR ROAD, N. E. / ATLANTA, GEORGIA 30305

TELEPHONE: (404) 261-9730



THE PERFECT GET-AWAY PLACE FOR YOU, YOUR FAMILY, YOUR COMPANY.

MOUNTAIN VIEW CONDOMINIUM VILLAS

Lake Arrowhead announces their brand new Mountain View Condominium Villas. These new Lake Arrowhead Condominiums are the most beautiful to be found anywhere—

- Rustic exterior design
- Central heat and airconditioning
- Fully equipped electric kitchen
- Washer/Dryer included
- Wood burning fireplace
- Wall to wall carpeting
- 2-1/2 baths
- Ample inside and outside storage
- Spacious sun deck
- Spectacular mountain view

Prices begin at $46,900

And here's more for you, after a nominal monthly maintenance charge and reasonable amenity fees!

- Membership in the Lake Arrowhead Country Club
- Championship 18 hole golf course
- Tennis and Swim Club
- 500 acre lake perfect for water sports and fishing
- Riding stables and mountain trails
- Picnic and recreational areas

For complete information and or personal inspection appointment call:

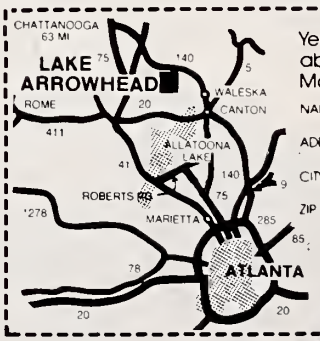
Lake Arrowhead Atlanta Office 266-1002

Or use this handy coupon.

Directions: From I-285 to U.S. 19 through Roswell to GA. 140. Once on GA. 140, follow the signs.

From I-75 go north to Roberts Road exit, then right to State Hwy. 5 to Canton, then north (left) on Hwy. 140 thru Waleska and follow the sign to Lake Arrowhead.

Lake Arrowhead is only 56 miles from Atlanta, 43 miles from Rome, 38 miles from Marietta, 21 miles from Cartersville, and 12 miles from Canton.



Yes, I am interested in learning more about Lake Arrowhead's brand new Mountain View Condominium Villas.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

LAKE ARROWHEAD

56 miles north of Atlanta...where a sound opportunity awaits you.

Another Diamondhead Corporation Community

THIS AD DOES NOT CONSTITUTE AN OFFER TO SELL IN ANY STATE WHERE SUCH AN OFFER IS PROHIBITED.

president's letter



Happy Holidays!

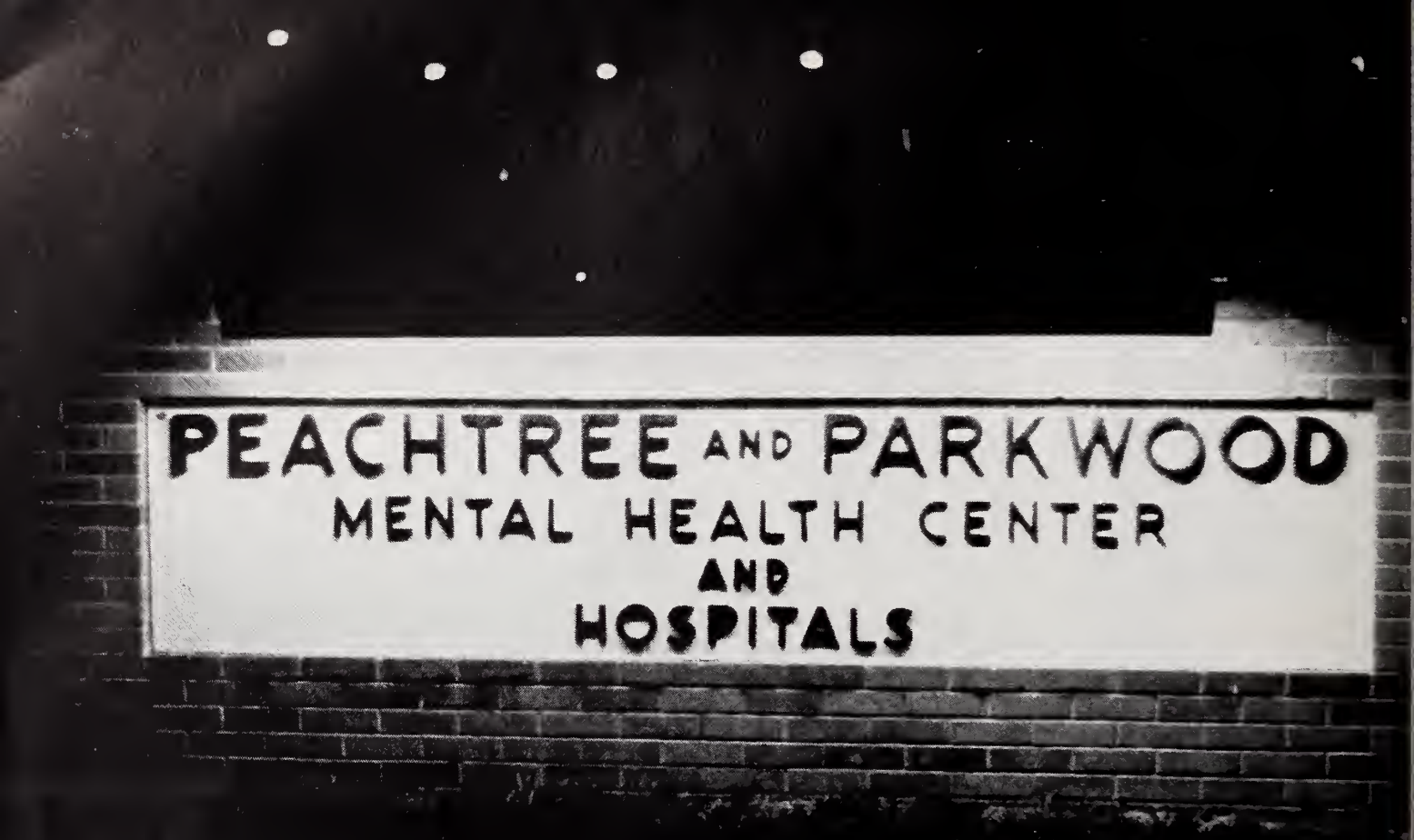
My message to you this month is very brief but most sincere. I wish to each and everyone a happy holiday and a most satisfying New Year!

My best to one and all—and to all, Good Night!

Sincerely,

Robert E. Perry Jr. M.D.

Robert E. Perry, Jr., M.D.
President, Medical Association of Georgia



All divisions—Adult, Alcohol, Child and Adolescent—separately accredited by the Joint Commission on Accreditation of Hospitals.

PEACHTREE AND PARKWOOD
Mental Health Center and Hospitals

1999 Cliff Valley Way, N.E., Atlanta, Georgia 30329 404/633-8431

I've told this before . . .

(Editor's Note: Things we take for granted today weren't always so easy. A good example of this is shared here by Dr. McDaniel. Others wishing to contribute to this page are invited to send their stories for consideration to the Journal of the Medical Association of Georgia, *938 Peachtree St., NE, Alanta, Ga. 30309.)*

Clipping from the Douglas (Ga.) Enterprise August 21, 1915:

DR. ROBERTS TAKES KIDNEY

Another very delicate and difficult operation was performed at the Douglas hospital on last Wednesday afternoon by Dr. C. W. Roberts, which was witnessed by several out of town doctors as well as many of the Douglas physicians.

The young man was Clinton Giles, of Nicholls, who, on the afternoon before was playing first base in a base ball game at West Green, the contesting teams being Nicholls and Denton. It seems that the runner on nearing the first base had to encounter young Giles, who was standing between him and the base, and in coming in contact with Giles, he, the runner, struck Giles with his knee in the side near the *stomack*. The boy did not complain so much at first, but later the pain became acute, and it was decided after a few hours to bring him to the hospital here.

Dr. Roberts says that there was very little sign on the body, something like a bruise about the size of a dollar, but from the symptoms and pains, and the passing of blood, the surgeon decided that the kidney was affected, possibly ruptured. So an operation was decided upon, and in a little while Dr. Roberts had taken from the patient the left kidney, which proved to be bruised and ruptured. The patient returned to Nicholls on the afternoon train, and the last reports are that he is doing fine.

The operation was witnessed by the following out of town doctors: Drs. W. L. Hall, of West Green; W. H. Dyer, of Nicholls, and H. C. McDermid.

An Act of Courage

SOME MONTHS AGO Dr. C. Purcell Roberts of Atlanta received this newspaper clipping about his father. It was sent by one of his aunts, who had found it tucked away among some old papers.

Purcell sent me a copy, since I assisted Dr. C. W. with many of his major procedures, knew him quite well and admired him very much. He was not only a great surgeon, but teacher as well. He was highly regarded by his comrades and was chairman of the AMA's Board of Trustees when he died in 1947.

Dr. "C. W." was born on a farm near the little town of Nicholls, Georgia, in 1883 and received his M.D. degree from the University of Maryland in 1906, with a certificate of honor for excellence in his examinations. He was resident surgeon at the University Hospital there from 1906 to 1908, when he returned to his old home county and practiced in Douglas until 1917. He was instrumental in building and operated the Douglas Infirmary (a county hospital) from 1911-1917 and then moved to Atlanta.

Purcell tells me that the patient in the case not only lived, but married his father's youngest sister, moved to Clinton, South Carolina, and became quite a successful businessman, retired and died only a few years ago.

It seems to me that this should be an inspiration to all doctors who tackle surgery. Just imagine now-a-days going after a ruptured kidney —without blood, or any type intra-nervous fluid—with no skilled help —anaesthetic given in the form of chloroform or ether—by one of the country doctors or maybe the druggist.

That, my friends, took courage—and still more courage to send the patient home on the afternoon train.

J. G. McDaniel, M.D.
820 W. Wesley Rd., NW
Atlanta, Ga. 30327



Lake Arrowhead. A guaranteed 8.6% annual return. And a great resort, too!

Take for example our million dollar Country Club that overlooks the sparkling 500 acre lake. Stretching out behind the Country Club is a magnificent hillside championship golf course, second to none in this entire area. We also have a beautiful Swin and Tennis Club with tournament courts and a huge pool, all waiting for your family.

Where does the guaranteed 8.6% annual return come in? It's made possible by our exciting and revolutionary marketing plan. If you purchase a Lake Arrowhead homesite under this plan, you will receive a guaranteed 8.6% annual return on the annuity premium upon maturity, which **will pay you back the original purchase price you paid for your beautiful Lake Arrowhead homesite and annuity.**

For complete information, call **266-1002** Visit our Atlanta office at 3400 Peachtree Road in the lobby of the Lenox Towers, or use this handy coupon. Remember, this is a limited offer.

Please send me free and complete information about Lake Arrowhead's new marketing concept under which I am guaranteed 8.6% annual return on the annuity.

NAME _____

ADDRESS _____

CITY _____ STATE _____

ZIP _____ TELEPHONE _____

Mail to: LAKE ARROWHEAD
3400 Peachtree Road
Lenox Towers
Atlanta, Georgia 30326

AMNG

LAKE ARROWHEAD

...where a sound opportunity awaits you.

Obtain the HUD property report from developer and read it before signing anything. HUD neither approves the merits of the offering nor the value, if any, of the property.
This ad does not constitute an offer to sell in any state where such an offer is prohibited.

Help Is Available in the Care of Your Patient With Cancer

J. MOULTRIE LEE, M.D., *Savannah**

AT TIMES, EVERY PHYSICIAN has problems deciding the optimum care for a patient and this can be especially true for the patient with malignant disease. Choices about proper regimen, where it should be administered and who should administer it have to be decided. In an attempt to help in solving these problems, may I suggest your Area Cancer Facility? Some years ago the State of Georgia was divided into 12 areas by the Georgia Regional Medical Program. As this Regional Program was phased out, the sponsorship of the 12 Area Cancer Facilities, each with its own Medical Director, was taken over by the Georgia Cancer Management Network, Inc.

The primary aim of the Area Cancer Facility is to insure that adequate facilities and trained personnel will be available to all patients with cancer within a relatively short distance of their homes. This area concept is not only more convenient for the patient, but also allows the primary physician, as well as the patient's family, to participate in the continuing care of the patient. These Area Facilities are generally more convenient than are the two medical schools within the state.

The purpose of this communication is to remind the physician that consultation is available through the Area Cancer Facility. The attending physician does not have to send his patient to a Regional Facility to obtain help in the treatment. Instead he has the options in most cases of telephone consultations with one of the members of his Area Facility or of referring the patient to one of these more convenient facilities. Frequently the decisions are many and a multi-disciplinary team should be involved.

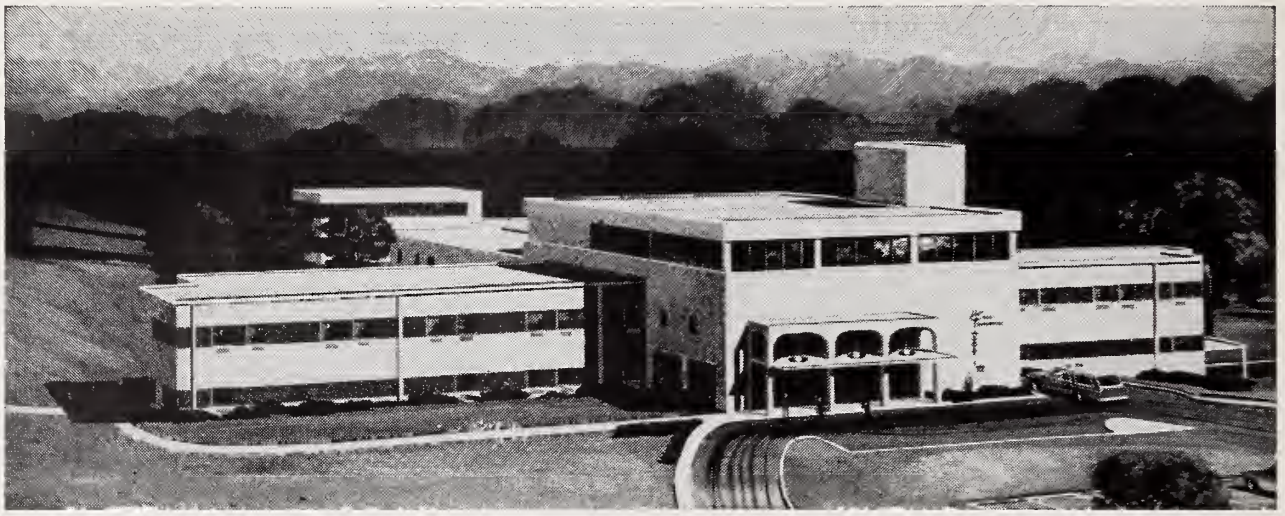
The Area Cancer Facility and the State Aid Clinics, although frequently in the same facility, are not synonymous organizations. The Area Facilities are listed below. Should you require information concerning proper consultations or referral, contact the Medical Director of your Area Cancer Facility.

GEORGIA CANCER MANAGEMENT NETWORK, INC. FACILITIES

Facility	*City*	*Director*
Atlanta Medical Center	Atlanta	John P. Wilson, M.D.
Augusta Radiation Therapy Ctr.	Augusta	Daniel Sullivan, M.D.
DeKalb General Hospital	Decatur	S. Angier Wills, M.D.
Emory University Clinic	Emory	Douglas R. Murray, M.D.
Enoch Callaway Cancer Clinic, Inc.	LaGrange	Hoke Wammock,
Eugene Talmadge Memorial Hospital	Augusta	Robert Johnson, M.D.
Floyd Hospital	Rome	M. D. Adair, M.D.
Grady Memorial Hospital	Atlanta	Melvin Moore, M.D.
The Medical Center	Columbus	John D. Watson, M.D.
Memorial Medical Center	Savannah	Robert Long, M.D.
Phoebe Putney Memorial Hospital	Albany	T. G. Fountain, M.D.
St. Joseph's Infirmary	Atlanta	Neil Perkinson, M.D.

* Chairman, MAG Cancer Committee. Dr. Lee's address is 200 E. 31st St., Savannah, Ga. 31401.

Prepared at the request of the Professional Education Committee of the Georgia Division of the American Cancer Society. Others wishing to contribute to this page should send their papers to David Roberts, M.D., 2025 Peachtree Rd., N.E., Atlanta, Ga. 30309.



HILL CREST HOSPITAL

FOR INTENSIVE TREATMENT OF PSYCHIATRIC DISORDERS

This 113-bed non-governmental psychiatric hospital provides modern facilities for diagnosis and treatment of patients with all degrees of illness, including those who show severely disturbed behavior. Alcoholic and drug abuse patients are also accepted.

In addition to care by psychiatrists and by consultants in all medical specialties, the treatment program includes occupational, recreational, and physical therapy, social services, and tutoring. Emphasis is on short-term, intensive treatment of voluntary patients.

Hill Crest is a member of: American Hospital Association, National Association of Private Psychiatric Hospitals, Alabama Hospital Association, Birmingham Regional Hospital Council.

Accredited by Joint Commission on Accreditation of Hospitals. Medicare Approved. Blue Cross Participating Hospital.

ADMINISTRATOR:
Robert V. Sanders

HILL CREST HOSPITAL

HILL CREST FOUNDATION, INC.

6869 Fifth Avenue South **Birmingham, Alabama 35212**

PHONE: 205-836-7201

Current Indications for Coronary Artery Angiography and Bypass Surgery—Part 2

GORDON C. MILLER, M.D., *Columbus**

Medical Treatment

Just as it must be ascertained if our patient's symptomatic response is acceptable to him, it also must be determined if he is actually receiving optimal medical management. We should very briefly outline what is generally considered appropriate medical therapy. Most importantly is advice on exertion. Most can and should proceed with their usual job, and should also walk some daily. But extremes of occasional exertion, such as grass mowing, should be avoided. At the earliest onset of angina, he should take nitroglycerine and rest. Long-acting nitrites as isosorbide would be added to some and then, if needed, propanolol. Reduction of aggravating factors and measures to offer the possibility of retarding the atherosclerotic process would include calorie and weight reduction, food lower in animal fat, cigarette abstinence, and blood pressure control. Patients require periodic reassessment of their treatment course and should be instructed to report to their physician a change in their angina's character such as increased frequency, duration, fatigue, or nausea.

Unstable Angina

Angina has been defined as unstable if it has one of the following characteristics: recent onset with severe recurrences, chronic angina with a recent acceleration in frequency, severity, or duration, or severe prolonged angina (sometimes called myocardial ischemia) or the intermediate syndrome. Prinzmetal's angina with ST segment elevation and fixed stenoses in older patients might also be included in this group.

The management course most recently prescribed is initial hospitalization with intensive drug therapy, including propranolol and nitrites. When the angina has subsided, angiography is proposed. The 3 to 11% with left main stenosis should have surgical bypass. Others should be followed as outpatients, but bypassed if they demonstrate disabling or recurrent unstable angina.[25] The rationale for this course is described by Scheidt who reports on 288 cases randomized in multiple centers. At two years, the mortality of the medical and surgical groups are the same at 5.0 and 5.2%, respectively. Symptomatic improvement was better in the surgical group, however, as only 15% remained in class III, whereas 45% remained in class III on medical therapy.[25] Two earlier randomized reports described similar mortalities at briefer follow-up periods of 4 and 7 months.[26, 27]

---

* Dr. Miller's address is 2300 Manchester Expressway, Columbus, Ga. 31904. Articles for this page are prepared at the request of the Committee on Physician Education of the Georgia Heart Association, Broadview Plaza, Level C, 2581 Piedmont Rd., N.E., Atlanta, Ga. 30324.

The generally followed management protocol for unstable angina has changed. Several years ago, it was approached with emergency angiography and bypass surgery.[28] It will be interesting to see how much additional experience as from longer randomized trials modifies current indications.

Myocardial Infarctions

For the acute uncomplicated infarction, angiography has not been indicated. But when balloon assist pumps, etc. are available, angiography has been recommended for acute infarctions complicated by recurring pain, severe pump failure, mitral regurgitation, ventricular aneurysm, and sometimes intractable ventricular tachycardia.[29-31]

Old infarctions are being angiogrammed in some centers as research. But routine angiography is not recommended in those cases without intolerable angina, heart failure or arrhythmia due to ventricular aneurysm.[29]

Subendocardial infarctions have been described by the Mayo Clinic group as an intermediate stage between unstable angina and transmural infarction. The latter occurring in 21%. They recommend angiography after 10 days, to describe the underlying severe stenosis.[32]

The Asymptomatic

In the asymptomatic suspect of coronary artery disease because of a positive treadmill test, angiography has not been recommended unless a left main lesion is suggested by treadmill ST segment depression exceeding 2mm, hypotension, or very low exercise tolerance.[29]

Other Indications

Coronary angiography has been found useful in cases undergoing cardiac surgery for other reasons, as for valve lesions. Recently we discovered a severe left anterior descending lesion in a candidate for pericardiectomy for constrictive pericarditis. Presently, routine post-operative bypass angiography is not recommended,[4] but it was certainly of use to us when we began. Out of a small sample of 24 vein grafts, we found a patency rate of 87.6%.[24]

Summary

Current indications for coronary artery angiography and bypass surgery might be divided into those indications upon which there is general agreement and those in which there is not at this time.

There is general agreement that: (1) Angina intractable to medical treatment should be angiogrammed and bypassed, if other considerations such as distal vessels and the ventricle are suitable. This is irrespective to whether there is one, two, or three vessel involvement. (2) Significant symptomatic left main stenoses should be bypassed. (3) Coronary angiography is useful for diagnostic problems, as in disproving the existence of coronary disease, or detecting left main stenosis in in suspect cases.

(4) There is still disagreement upon the indication for bypass to improve longevity and to protect the myocardium in angina easily tolerable with two- and three-vessel disease whether chronic or unstable. At this time of rift between retrospective and prospective reports, we anticipate further studies, but also each physician should reflect on his own experience in this area.

It becomes obvious in practice that each case must be considered individually. In each case, multiple factors must be considered simultaneously including symptoms, the patient's estimate of how much his angina actually bothers him, treadmill response, angiogram findings including the number of vessels narrowed, degree of narrowing, distal vessels, collateral flow, the ventricle's preservation, and the patient's prerogative. Longevity is not the only consideration. Although we physicians should make recommendations to the patient, the risks should be simply

explained to the patient so that he can express his prerogative. He may have values and factors to consider that he is unwilling or unable to express.

On reflecting on the different indications for coronary angiography and surgery, it appears that the knowledgeable use of the clinical indices is still an essential and integral part of the decision making.

INDICATIONS FOR CORONARY ARTERY ANGIOGRAPHY AND BYPASS SURGERY*

Clinical Presentation	*Angiogram*	*Bypass*
Angina of recent onset (subsided)	No	
Diagnosis needed		
Problem angina but uncertain	Yes	
Airline pilots, etc.	Yes	
Chronic angina		
Occasional	No	No
Stable, tolerable	No	No
Incapacitating		
Untreated	No	No
Treated, unresponsive	Yes	Yes†
With resting ST depression or treadmill 2mm	Yes	Yes†
Unstable angina		
Untreated	No	No
Treated, unresponsive	Yes	Yes†
Prinzmetals		
Fixed stenosis (mature)	Yes	Yes†
Spasm (younger females)	Yes	No
Left main stenosis suggested by severe unresponsive angina, or treadmill hypotension(chronic or unstable)	Yes	Yes
Myocardial infarction		
Evolving	Research	Research
Completed		
Uncomplicated	No	No
With continuing pain	Yes	Yes†
Low output	Yes‡	Yes†
Mitral regurgitation	Yes	Valve surgery
Old		
Angina, absent or controlled	No	No
Angina, severe or unstable	Yes	Yes†
Subendocardial infarction	Yes	Yes
Asymptomatic		
Treadmill positive, mildly	No	No
Treadmill very positive: 2mm or hypotension	Yes	Yes†
Other cardiac surgery	Yes	Yes†
Ventricular arrhythmias, intractable	Yes	Yes†
Unheralded cardiac arrest survivors	Yes	Yes†
Post-operative bypass evaluation	Circumstantial	

* Note: This chart may be an oversimplification, but so qualified it should still be useful to give perspective.
† If other factors suitable.
‡ If equipped.

Editor's Note: An extensive bibliography for this article is available upon request from the Medical Association of Georgia.

ERRATUM—In Part 1 of this article, November 1977: Page 904, third complete paragraph, the third sentence should read "At *five* years, the overall mortality . . ."; In the sixth paragraph, 10th line, 22mm should be *2 mm:* page 905, third line, Ventricular should be *Ventricle.*



CREDITORS
MERCANTILE,
INC.

Doctors & Hospitals
Service Bureau

COLLECTION ACCOUNT CONTROL SYSTEM

Our Professional Collection System Insures:

- Easy Placement of Delinquent Accounts
- Prompt, Regular Follow-up
- Professional Telephone Contacts
- Approved Notices and Letters
- Bonded and Insured Protection
- High Recovery Ratios
- Maintenance of Customer Goodwill

We understand your credit
and collection problems.

Established 1914

Charter Member American
Collections Association
Member Associated Credit
Bureaus, Inc.



4 Executive Park Dr., NE, P.O. Box 95806, Atlanta, Ga. 30347 (404) 321-0999

legal page
legal page
legal page

Medicare-Medicaid Anti-Fraud and Abuse Amendments

RICHARD H. VINCENT *and* ROBERT N. BERG, *Atlanta**

IN RECENT YEARS, NUMEROUS hearings, studies and investigations have been undertaken by Congressional committees, and by both federal and state agencies, in the area of provision of health care services financed by the Medicare and Medicaid programs. These committees and agencies have suggested the existence of a broad range of improper activities associated with the provision of these services, activities which are not restricted to one particular class of providers or treatment settings. These activities are allegedly costing billions of dollars each year; for example, Secretary of Health, Education and Welfare (HEW) Joseph Califano Jr. has estimated that, just in terms of payments of ineligible Medicaid claims, "we're throwing $1 billion a year away in this country."[1]

To combat this problem, and "to strengthen the capability of the government to detect, prosecute and punish fraudulent activities under the Medicare and Medicaid programs,"[2] Congress recently passed, and President Carter has signed into law, the "Medicare-Medicaid Anti-Fraud and Abuse Amendments."[3] The Amendments are focused on five major areas: (1) strengthened program penalty sanctions; (2) increased disclosure of information; (3) needed improvements in the Professional Standards Review program; (4) administrative reform, and (5) technical revision.

Program Penalty Sanctions

The crux of the Amendments is to increase the penalty provisions for fraudulent acts committed by Medicare and Medicaid providers. In that context, fraudulent acts committed by providers which in the past were classified as misdemeanors, will be classified in the future as felonies; consequently, violations will be punishable by a fine of up to $25,000 or by imprisonment of up to five years, or both. A new penalty has been added under Medicaid whereby anyone who willfully charges a Medicaid patient "at a rate in excess of the rates established by the state" would be guilty of a felony. Moreover, the Secretary of HEW will be required to suspend from participation in the Medicare or Medicaid programs any individual practitioner who has been convicted of a criminal offense related to such practitioner's involvement in the programs.

Disclosure of Information

The Amendments will require all institutional providers and suppliers participating in the Medicare and Medicaid programs to disclose, upon request, certain ownership information and information pertaining to business transactions with related parties. These disclosure rules do not apply to any individual practitioner or group of practitioners, but they do apply to institutional providers, independent clinical laboratories, health maintenance organizations, Medicare carriers or intermediaries, and Medicaid fiscal agents—as well as to any subcontractor which

* Prepared at the request of the Medical Association of Georgia. Mr. Vincent is a partner and Mr. Berg is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, 1100 C&S National Bank Building, Atlanta, Georgia 30303.

is owned five percent or more by the reporting entity.

Professional Standards Review

The Amendments include several provisions designed to clarify the nature and scope of Professional Standards Review Organizations (PSROs) to enable PSROs to be more effective in performing reviews of the necessity and appropriateness of program services and to improve the administration and coordination of review activities. One of the more important of these provisions will allow the Secretary of HEW to terminate duplicative review activities following a determination that a PSRO is competent to perform its review activities; when a PSRO is found to be competent in the areas of review of medical necessity and appropriateness of care, its findings become conclusive for purposes of Medicare and Medicaid payment. States are given the option of monitoring PSRO reviews, however, and if PSRO reviews result in unreasonable and detrimental impacts on state expenditures and Medicaid health care, then the Secretary can suspend the conclusiveness of the PSRO's review. Other features of the Amendments as they relate to PSROs will (a) permit extensions of conditional PSRO designation for 24-48 additional months; (b) require a fully designated PSRO to undertake ambulatory care review within two years of full designation; (c) permit a PSRO to disclose, at its discretion, evidence of fraud to designated federal and state law enforcement agencies; (d) require federal reimbursement of legal costs incurred by PSROs in defending liability suits involving the performance of PSRO duties, and (e) provide certain civil immunities for PSRO members and PSRO patient records.

Administrative Reform

The Amendments will require states to provide, in their State Medicaid plans, for claims payment procedures which insure the speedy reimbursement of bills submitted by noninstitutional providers: ninety percent of "clean" bills must be reimbursed within thirty days and ninety-nine percent wihin ninety days. Also, the Amendments provide for temporary federal matching funds for expenditures by states wishing to establish and operate State Medicaid fraud control units.

Technical Revision

In the technical area, the most notable features of the Amendments clarify the existing law to insure that a power of attorney cannot be employed by providers to circumvent the ban against the use of "factoring arrangements" in connection with the payment of provider claims. Additionally, the Amendments clarify the definition of "shared health facilities" for purposes of review by PSROs.

Potential Impact of the Amendments

The most widespread impact of the Amendments will be in the area of disclosure of information, since the expanded disclosure requirements will apply to hospitals, skilled nursing facilities, home health agencies, independent clinical laboratories and certain health maintenance organizations. Moreover, the Amendments will result in increased program costs as the necessary regulatory modifications are implemented. In the future, however, cost savings are expected to be generated by the Amendments as a result of the expected deterrence of fraudulent or abusive activities, as well as the denial of payments and the recovery of payments inappropriately made.[4]

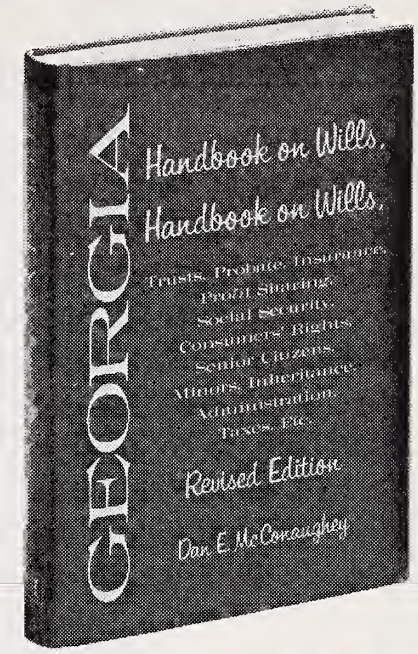
NOTES

1. This projection is based on a finding that, for the three-month period between April and September of 1976, improper payments for Medicaid claims amounted to $229 million.
2. Report by the House Committee on Ways and Means, June 7, 1977.
3. Public Law 95-142.
4. Report by the Senate Finance Committee, September 26, 1977.

The general public has more interest in the field of Wills, Inheritance, and Administration of Estates than any other field of the law.

People constantly talk about what happens when a man dies without a will — or with a Will. Does the poor widow starve to death? How does a person contest a Will? Are attorney's fees and court costs fair or outrageous? Is there some gimmick that can eliminate all of these problems?

These questions and many others are answered in this valued book based strictly on Georgia law for Georgia citizens in language easy to understand.

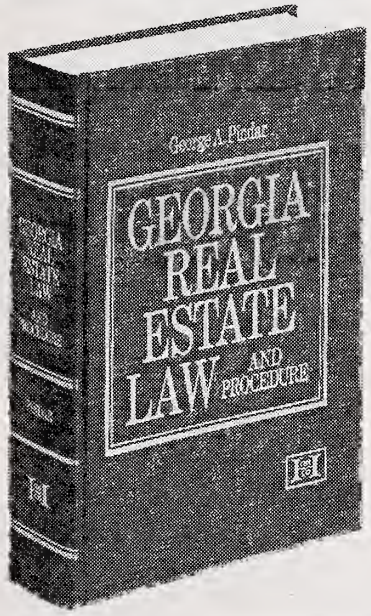


Completely updated
New chapters added

*How NOT to invest your money
*Pension and profit sharing plans
*Consumer rights
*PLUS the Tax Reform Act of 1976 is discussed

Copyright 1976, 302 pages, dimensions 6" x 9", hardbound cover in brown, yellow and orange.

An Essential Tool for anyone dealing in Georgia Real Estate



No other book provides a more detailed coverage of the Georgia Law as it pertains to every phase of real estate.

This handsomely bound book is a must for the library of every person dealing with Georgia Real Estate Law.

WITH 1978 SUPPLEMENT

Copyright 1971, 6 3/4" x 10", 1,350 pages, Hardbound. Annual pocket part supplement.

ORDER CARD

Please enter my order for the publications listed below, including supplements, revisions and related material. I understand I may at any time cancel my order for the supplements, revisions, etc., by so informing The Harrison Company in writing.

☐ McConaughey's **GEORGIA HANDBOOK ON WILLS** $9.95
☐ Pindar's **GEORGIA REAL ESTATE LAW with '78 Supp.** $57.50

Georgia Residents Add 3% Sales Tax
(Add 1% MARTA or Local Option Sales Tax to all above prices where applicable)

Cash Sales are shipped postpaid. ALL OTHER SALES will have actual postage OR freight charges added.

Prices Subject to Change Without Notice

☐ Bill Personal Account ☐ Bill Firm Account
☐ I enclose check or money order for $_____

Please Charge My ☐ BankAmericard ☐ Master Charge

your BANKAMERICARD welcome

master charge THE INTERBANK CARD

MY BANK CREDIT CARD NUMBER IS

INTERBANK NO. _____ EXP. DATE MO. YEAR

Name _____
Address _____
City _____
State _____ Zip _____
Date _____ Signature _____

ALL ORDERS MUST BE SIGNED 77-1G

THE HARRISON COMPANY, PUBLISHERS
3110 Crossing Park • Norcross, Georgia 30071 (404) 447-9150

don't just stand there...

When it comes to executive seating your quality office product companies don't bring up the rear. We're set up to move fast. With on-time immediate delivery on these CHROMCRAFT classics. And talk about comfort. Sit in one of our Classic chairs. You'll feel the deep-down luxury of contour molded foam cushioning. All Classic chairs are available in fire retardant vinyls and foam that meet all state and federal recommendations. At no extra charge. Classic chairs are guaranteed against structural failure for a full 12 years. Upholstery materials are guaranteed for two full years. New double-torsion tilt mechanism gives theater seat comfort. Full swivel with telescoping hand-wheel height adjustment. And the prices are right! For information, visit our showroom or call **NORTH DEKALB OFFICE SUPPLY, INC.**, 5404 New Peachtree Road, Chamblee. 404-457-2524



the association
the association
the association

NEW MEMBERS

Alperin, Henry, Richmond—Act—R
1450 Winter St., Augusta 30904

Barlow, Richard E., MAA—Act—R
P.O. Box 26129, Grady Hospital, Atlanta 30203

Bernstein, Richard B., MAA—Act—N
3280 Howell Mill Rd., NW, Atlanta 30327

Boyle, Stephen, Newton-Rockdale—Act—GS
2192-B Salem Rd., Conyers 30207

Brandenburg, David S., MAA—Act—GE
340 Boulevard NE, Atlanta 30312

Connelly, Timothy Lee, DeKalb—Act—GS
1084 Rays Rd., Stone Mountain 30083

Elsahy, Nabil Ibrahim, Richmond—Act—PS
Medical College of Georgia, Augusta 30904

Fradkin, Maury L., MAA—Act—OBG
5675 Peachtree Dunwoody Rd., NE, Atlanta 30342

Garcia, Casimiro S., MAA—Act—OBG
340 Boulevard NE, Atlanta 30312

Gelbart, Arthur O., Richmond—Act—FP
Medical College of Georgia, Augusta 30901

Green, Joseph B., Richmond—Act—N
Medical College of Georgia, Augusta 30901

Krakow, Richard A., MAA—Act—D
607 Holcombe Bridge Rd., Roswell 30075

Loftis, William E., Richmond—Act—R
1467 Harper St., Augusta 30902

Mims, LeRoy C., Richmond—Act—PD
Medical College of Georgia, Augusta 30902

Mouna, Youssef, Richmond—Act—IM
1109 Medical Center D, Augusta 30909

Rigel, Edward P., Hall—Act—ANES
Northeast Ga. Medical Center, Gainesville 30501

Schmidt, Robert M., MAA—Act—HEM
1600 Clifton Rd. NE, Atlanta 30332

Williams, David C., Cobb—Act—GS
245 East Griffin Ave., Dallas 30132

SOCIETIES

Mrs. Russell E. Andrews, state president of the **Auxiliary to the Medical Association of Georgia,** spoke at a luncheon meeting of the **Baldwin County Medical Auxiliary** in October about the meaning of different aspects of auxiliary work and the necessity of every auxilian to work together to achieve the club goals.

Atlanta and DeKalb Medical Wives Auxiliaries co-hosted a forum entitled "What's New Under the Gold Dome for Medicine in 1978?" at Ansley Golf Club in October. The Panel featured Georgia Representatives George Williamson and Sydney Marcus and Senators Pierre Howard and Virginia Shepard.

PERSONALS

Second District

Laurence T. Crimmins, M.D., of Albany, and **Charles E. Zimmerman, M.D.,** of Tifton, were named Fellows of the American Academy of Family Physicians during recent ceremones in Las Vegas.

Radiologist **Robert G. Dunn Jr., M.D.,** of Albany, retired from Phoebe Putney Memorial Hospital after 27 years of service.

Fifth District

William G. Avery, M.D., of Atlanta, has been appointed as the new chairman of the medical staff at Northside Hospital.

Hapeville physician **Bruno Denis, M.D.,** has become a Fellow of the American Academy of Family Physicians during ceremonies in Las Vegas.

J. C. Tanner Jr., M.D., of Atlanta recently collaborated with an Atlanta dentist in the development of a new dental diagnostic aid for determination of adequacy of pulp blood flow. A description of this instrument appears in the September 1977 issue of *Dental Surgery.*

Ralph Mark Wilkiemeyer, of Atlanta, has been elected to the American College of Surgeons.

Sixth District

Henry T. Clay, M.D., of Macon, has been named a Fellow of the American Academy of Family Physicians.

Seventh District

Calhoun physician **Joseph A. Bishop** has been named a Fellow of the American Academy of Family Physicians.

Eighth District

Patterson physician **Carlos R. Triana** has been named a Fellow of the American Academy of Family Physicians.

Ninth District

Harold G. Long, M.D., of Dahlonega, has been

EAC

Aircraft Acquisition/Sales
Free Consultation

J. L. (Larry) Scott
J. W. (Pete) Smith

Executive Aviation Corporation
1951 Airport Road, Atlanta, Georgia 30341
404/458-8956

For Practice Management Information Systems...

Call The Specialists
Call Systemedics

- FOR improved cash flow and financial control
- FOR automatic processing of patient statements and insurance information
- FOR improved patient management through use of our Problem Oriented Record
- FOR continuing service and management assistance

Serving medical practices exclusively

Systemedics of Georgia
P.O. Box 28055
Atlanta, Ga. 30328
(404) 252-3835

named to the Lumpkin County Hospital Authority. He is the first doctor of the staff to serve on the Authority.

Tenth District

Ernest J. Jones, M.D., of Covington, and **Asa Daniel Duggan, M.D.,** of Washington, were named Fellows of the American Academy of Family Physicians.

Practice Management Workshop Scheduled

For the fifth consecutive year, the Medical Association of Georgia and the AMA will sponsor a Practice Management Workshop specifically designed for residents. Entitled "Establishing Yourself in Medical Practice," the workshop will be held at the Ramada Inn—Atlanta Central, January 31-February 1, 1978.

Registration fee for state medical society or AMA members is $100 and for non-members $125. The fee covers all materials and two lunches. Spouses are welcome to attend as observers at an additional fee of $7.00.

Topics covered will include personnel recruitment and management, patient flow techniques, physical aspects of the medical office, filing and billing systems, practice settings and legal problems.

For registration information, write to Division of Education, Medical Association of Georgia, 938 Peachtree Street, Atlanta, Georgia 30309 or phone (404) 876-7535.

Letters to the Editor

Dear Sir:

I am writing you regarding the MAG program for disabled physicians. I am a member of a group who suddenly found itself with a member who had a problem with alcohol. I say suddenly because it was a sudden realization of an insidious problem. The problem is also one of where to turn for help and what to do.

We knew a physician who had been through this program successfully and he got us in touch with Dr. Talbott. Dr. Talbott was very helpful and very understanding. This resulted in our associate entering the program.

We could not be more pleased with the way things were handled by Dr. Talbott and his associates. If there is any program that MAG has that is more worthwhile than this one, I cannot think of it. If this were the only thing that MAG did, it would be a very worthwhile organization.

Name Withheld

(Editor's Note: For details on this program, see the October 1977 issue of the *Journal,* p. 777.)

ERRATUM

On page 785 (October 1977), the second *full* paragraph should begin "Wynder and Shigematsu reviewed largely negative results from studies by Stocks, Pernu, and Higginson, and in 1967 . . ."



Kenneth M. Williams, Director of Public and Professional Relations.

MAG Welcomes New Staff Members

On October 10, 1977, Kenneth M. "Ken" Williams joined the MAG staff as Director of Public and Professional Relations, replacing Charlie Templeton, who had been in that position since 1972.

Mr. Williams has Masters Degrees in Administration and Supervision and Bachelor Degrees in Economics, English and Sociology from Western Kentucky University, Bowling Green. He most recently was Vice President of Commercial Realty Trust Corporation, a real estate brokerage firm in Nashville, Tennessee. Before that, he was Executive Director of the 5,000-member Memphis Education Association (1972-74) and Field Representative for the Tennessee Education Association (1969-72).

He brings with him a wealth of experience dealing with professionals' problems with government and the press. In his first two months, he has established effective communication links with the working press throughout the state.

Also on October 12, the *Journal* of MAG added a new staff member, Caffilene "Cathy" Allen, in the position of Assistant Managing Editor.

A recipient of the Women in Communications scholarship, Ms. Allen is now completing her Journalism Degree from Georgia State University, where she maintains a 3.65 grade-point average. Her journalism background includes working at the *Atlanta Journal* as a writer. She has already proved to be a valuable asset to the *Journal* and to MAG.



Caffilene Allen, Assistant Managing Editor, *Journal*.

Estes Surgical Supply Company

—SINCE 1908—

EXAMINATION FURNITURE
OFFICE FURNITURE
LAB SUPPLIES
ELECTROCARDIOGRAPHS
PHYSIOTHERAPY APPARATUS
SURGICAL SUPPLIES & INSTRUMENTS
SUNDRIES
X-RAY SUPPLIES
COMPLETE OSTOMY LINE

351-2011
890 CHATTAHOOCHEE AVE., NW
(NEAR I-285 & I-75 N.)

Specializing In The
Repair
Lease
and
Selling
Of Imported Cars

Porsche - BMW - Mercedes
Audi - Volvo

FRANZ BLAM RACING
2040 STEEL DRIVE • TUCKER, GA. 30084 • 939-6100

How To Be More Of A Doctor

(And Less Of An Office Manager)

If you're like most physicians you're interested in maximizing the time you can devote to patient health care and minimizing the time you must spend on office business matters.

Those are the basic objectives that MI/Professional Management can help you accomplish. More than 1,800 professional clients in the Southeast use our consulting services in improving the business and financial aspects of their practices, generating additional income and controling operating and overhead costs. We'd be pleased to meet with you to discuss the ways we might assist you in becoming more of a doctor – – and less of an office manager.

Business Consultants to the Professions Since 1951



MI/Professional Management

1200 RIVERSIDE DRIVE, SUITE A MACON, GEORGIA 31201 (912) 742-3274
1209 MOICE DRIVE DALTON, GEORGIA 30720 (404) 226-3704

North Carolina: Asheville, Charlotte, Greensboro, Kinston, Raleigh, Salisbury, Southern Pines, Wilmington, Winston-Sal
Tennessee: Columbia, Kingsport, Knoxville, Nashville
Virginia: Danville, Lynchburg, Norfolk
Pennsylvania: West Chester
South Carolina: Florence
Georgia: Dalton, Macon

"MAGNET '77 was the best ever! It was the best-organized practice management workshop I've ever witnessed. It was a steal!"—Marvyn D. Cohen, M.D., MAGNET Chairman and Chairman of MAG's Communications Committee.



Marvyn D. Cohen, M.D.

MAGNET '77: An Overwhelming Success

On October 22 and 23, 104 people (physicians, medical assistants and business managers) gathered at Atlanta's Terrace Garden Inn to take advantage of a program which promised to give them valuable information for improving the efficiency of their medical practices.

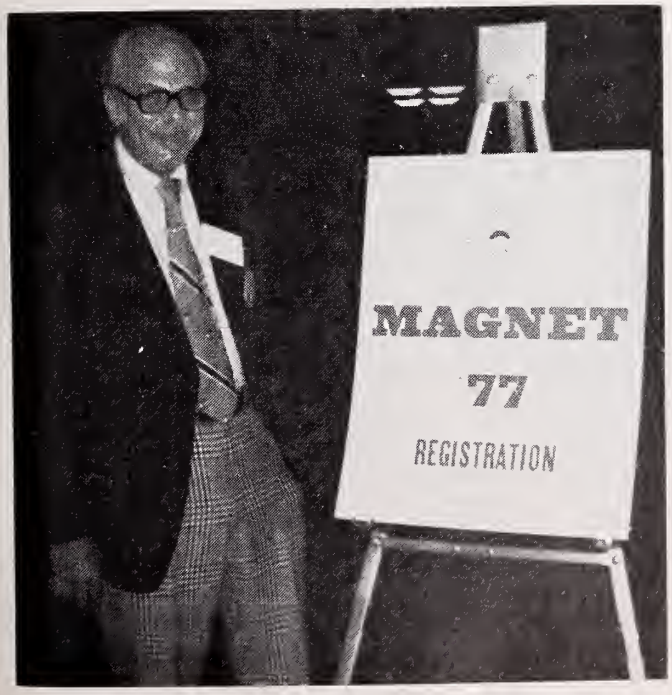
Apparently, MAGNET '77 lived up to its billing. Attendees filled out an evaluation after attending the workshops. Ninety percent evaluated the overall program as "valuable and informative"; nine percent considered the material "valuable for the most part." The speakers were rated "excellent" by most participants and "good" by the rest.

During the first day, professional management consultants presented programs on such subjects as collections, time management, insurance, staff problems and computers. On the second day, a communications specialist led a discussion on the importance of two-way communication. Attendees participated in several exercises in listening and received pointers on how to be a more effective speaker—before a group and on a one-to-one basis. Most of the participants left the conference inspired and feeling they had received valuable information which they would use in changing their practices.

Comments about the program: "Continue as you are going." "A great program!" "Keep it up!"

Anyone contemplating attending next year's conference should talk to any of this year's participants to find out just how valuable this MAG service can be.

"Although attendance was good," said Dr. Cohen, "I'm sorry that more people did not take advantage of this opportunity. It was a steal!"



MAG President Robert E. Perry Jr., at MAGNET '77.

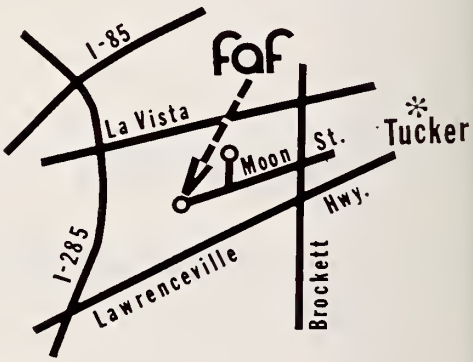


Driving the 308GTB puts you in an entirely different world of automotive experience. To quote *Autocar*—"All round, one is lost in admiration for the superb quality of the mechanical engineering, the standard of finish of the body and interior details, and the all-round efficiency. It is the best Ferrari we have driven."

Test drive the 308GTB as our guest (it's priced about the same as some Mercedes and Porsche models). Driving will never be the same after you experience Ferrari. You will have known the Ferrari mystique.

DO ALL DOCTORS DRIVE MERCEDES?

No. Some enjoy the unique experience only a Ferrari delivers.



faf motorcars inc.

AUTHORIZED FERRARI SALES • SERVICE • PARTS

3862 Stephens Court, Tucker, Ga. 30084 **(404) 939-5464**

For your patient who wishes to break an addictive lifestyle . . .



Wellspring

An Intermediate Care Facility for the Intensive Treatment of Alcohol and Drug Addiction

A medically oriented, moderately priced facility for the intensive treatment of alcohol and drug addiction. The treatment plan includes: individual and group therapy; educational processes, such as films, lectures and discussions; study groups; AA meetings; planned recreation, and the milieu of community living with others who have similar problems. Intermediate care is an intensive treatment period dedicated to giving patients personal insight into their addictive problems and helping them plan alternate lifestyles in which they can live successfully. For more information, contact the directors:

The Rev. Dr. Ralph O. Marsh
Carl W. Smith, M.D.
James C. Cooper, Ph.D.

247 Milledge Ave., Athens, Ga. 30605
(404) 546-1215

Physician Recruitment Conference/ Pre-Practice Seminar

OCTOBER 21-23, 1977

CALLAWAY GARDENS, PINE MOUNTAIN, GEORGIA

In recognition of the shortage of medical care in non-urban Georgia and Alabama, the MAG Committee on Access to Health Care joined with the Southeastern Institute for Community Health, Inc. (SICH), LaGrange, for a three-day conference at Callaway Gardens. The purpose of the conference was to encourage new physicians to enter practice in rural areas.

With the assistance of a grant from the Callaway Foundation, Inc., LaGrange, the MAG and SICH invited second and third year residents in family practice, pediatrics and internal medicine from Georgia, South Carolina, Florida and Alabama to attend the conference. Also invited to attend were communities in Georgia and Alabama who have recognized a need for physicians.

During the first day of the meeting, the community representatives heard speakers and participated in panels on how to recruit physicians and make them aware of the various programs available to help them. Some of the topics were: MAG's Physician Placement Service, presented by M. C. Adair, M.D., Rome, Chairman of the MAG Committee on Access to Health Care.

In addition to the formal program for the community representatives, each community was allocated an area for setting up a small exhibit for showing their communities and for meeting with the doctors. This area was very active during the allotted times of the next two days, and the community representatives were quite pleased with the opportunity to meet and talk with the 41 physicians who attended the Pre-Practice Seminar.

The program over the next two days was developed to aid the new doctors in their process of beginning private practice and opening a new office.

The first panel, entitled "Meeting the Demand" and moderated by M. Julian Duttera, M.D., President of SICH, discussed: better utilization of nurses, by Ladd W. Hamrick, M.D., Concord, N.C.; physician extenders, Dr. Duttera, and adding additional physicians, by Ollie O. McGahee, M.D., Jesup, Georgia.

The afternoon session included a panel entitled "Quality of Life," moderated by Robert B. Copeland, M.D., LaGrange. The subjects discussed during this panel were: practice arrangements, Mr. George J. Polli, AMA, Chicago, and social considerations, Dr. Copeland.

The second panel of the afternoon dealt with government issues, moderated by John Ball, M.D., J.D., Robert Wood Johnson Clinical Scholar, Bethesda, Maryland. Speakers on this panel were: Mr. Robert Youngerman, Executive Director of the North Central Georgia Health Systems Agency, who discussed the Health Systems Agencies, and Dr. Ball, who discussed professional liability and PSRO.

At the conclusion of the second panel, the physicians were again given an opportunity to visit with the communities.

The final session on Sunday morning featured a panel entitled "Quality of Care," moderated by Robert Mullins, M.D., Langdale, Alabama.

The Pre-Practice Seminar ended with a discussion of economic issues presented by Practice Productivity, Inc., and evaluation questionnaires were distributed to physicians and community representatives.

The responses from community representatives were favorable and many requested that the seminar be repeated next year. Physicians expressed great appreciation for the opportunity to meet with communities and attend the panel sessions which they felt were informative and relevant.

A follow-up evaluation questionnaire will be mailed to physicians in approximately six months to determine exactly how many have decided to locate in a particular community as a direct result of the Physician Recruitment Conference and Pre-Practice Seminar.





The Seminar provided an informal setting in which physicians could meet with representatives from communities which have doctor shortages.

When your patients have problems they turn to you. . . .

When your practice has problems whom do you turn to?

FHC
Family Health Care, Inc.

Family Health Care, Inc. *provides a comprehensive range of management services for the diagnosis and treatment of practice problems.*

- Organization
- Patient Flow
- Medical Records
- Personnel Management
- Administration
- Financial Management
- Trendline Evaluation
- New Practice Development
- Planning for Practice Expansion

For further information about our services contact:

Don Jones, M.B.A.
Regional Director
Family Health Care, Inc.
6065 Roswell Rd., Suite 320
Atlanta, Georgia 30328
(404) 256-4825

Money Available

For:

- **Established Doctors**
- **Physicians in Training**
- **Military (GS-12 and above)**
- **Executives or Educators with salary of $20,000/yr. or more**
- **Airline Pilots**

Unsecured Personal Loans
$5,000 to $25,000, up to 5 years to repay
No prepayment penalties

Loans made anywhere in Georgia and in most other states. Handled by mail for your convenience.

Hosmer & Associates
P.O. Box 28526,
Atlanta, GA 30328
(404) 255-0714

MEDICAL
Linde
OXYGEN
WALKER
DISTRIBUTOR
SERVICE, INC.

WE SELL
SERVICE

935 Jefferson St., N.W.
Atlanta, Ga. 30318 ● (404) 875-4058

MAG President Speaks Out Against NHI

On October 28, 1977, the U.S. Department of Health, Education and Welfare held hearings in Atlanta on the subject of National Health Insurance. Robert E. Perry, M.D., President of MAG, appeared at those hearings to make a statement for the Association. The following is a summary of and excerpts from his presentation.

Dr. Perry opened by describing the American medical system and questioning the motives of the hearings:

"Our technology and professional skills are a magnet for the best brains and the most seriously ill people from around the world. In short, we must be doing something right. Even our severest critics acknowledge that we have the finest medical care in the entire world today.

"As these facts are virtually undisputed, we can ask the question, exactly why are we here today? Are these hearings being conducted to honestly gather recommendations regarding national health insurance, or are we merely helping to compile a record to justify conclusions already reached at the highest political level in the land? Indeed, where is the evidence that the American people want national health insurance?

Dr. Perry pointed out that the most recent polls conducted by all the leading pollsters reveal that *"Americans in overwhelming numbers are satisfied with both the quality and availability of their medical care. A clear majority of Americans say they are satisfied with their medical care, that they can find a doctor when they need one, and that in general the American system of medical care—delivered in large part by the private physician in his office or to his patients in the hospital—works well."*

The subject of cost was brought up, as Dr. Perry questioned whether or not Americans are aware of the tremendous price tag attached to national health insurance:

"Unfortunately, the American people have not been told of the costs necessary to administer national health insurance, nor has the public been told of the huge expenditures necessary to support the massive bureaucracy that could run from 20 to 50% of the total funds allocated for the program.

"Secretary Califano perceives health care as a very costly item. He's right. But will national health insurance make any improvement toward containing costs?

"The cost of national health insurance will be more than any of us can ever afford."

Absolutely not! On the contrary, national health insurance, like any other federal program that pumps billions of dollars into the economy, will serve only to drive costs up, fan the fires of inflation and, in general, make matters worse.

"Those who look to a 'free' but frighteningly expensive Kennedy-style bill to reduce inflation in medical costs are really saying that the way to extinguish a fire in an oil refinery is to spray the flames with more oil. Utter nonsense!"

What would the results be in terms of quantity and quality of health care?

"The strain of health resources that virtually any national health insurance plan would engender is such that rationing of care, or rationing of the quality of such care, or limiting access to care seems a certainty. We have only to examine the experiences of Great Britain, Canada or Australia to see the threats of rationing of health care."

"Proponents of national health insurance fail to mention that their proposal for containing costs is nothing more than a cutback in the quality and quantity of care."

Dr. Perry pointed to the fact that in England, 600,000 patients are on waiting lists six months to four years for elective surgery. And British hospital standards are way below those in America.

"The rationing of care is one of the tragic realities of a system under which the government over-promises on what it can deliver, thus raising the level of expectation at the same time it invokes cost control as its first principle.

"Proponents of national health insurance fail to mention to the American people that their proposal for containing costs is nothing more than a cutback in the quality and quantity of care."

And what about the government's excellent record of creating more problems with its "solutions"?

"The federal government has a very bad record indeed, when establishing new national programs. Every time the federal government initiates programs to aid the poor and disadvantaged, the inflationary impact caused by increased government spending has just the opposite effect from that intended. The poor, and those living on a fixed income, are inevitably the ones hurt the most.

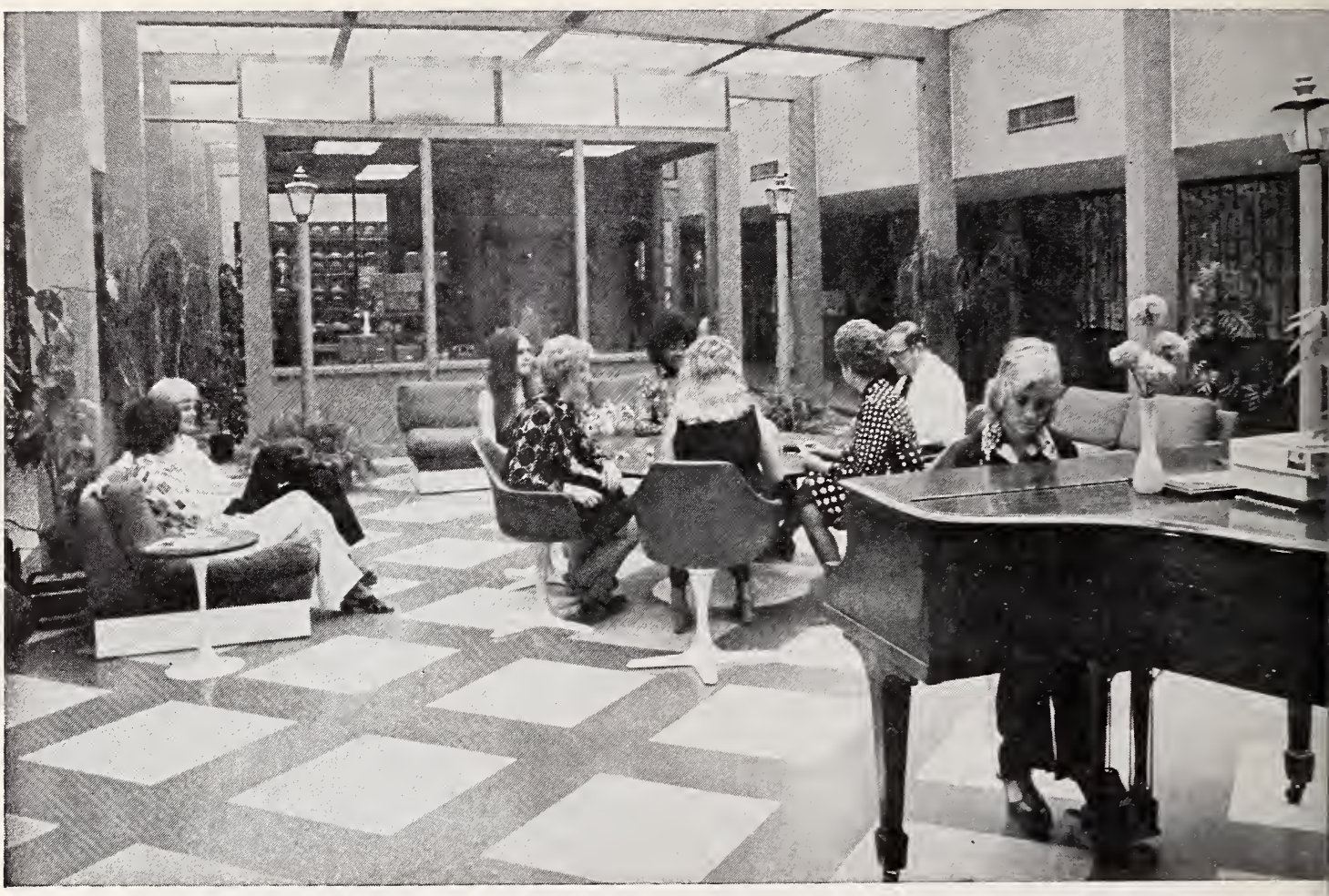
"When Medicare was being debated in Congress in the early 1960s, the AMA warned repeatedly that the government was vastly underestimating costs. In actuality, the program cost twice as much the first year as was predicted.

"There is no such thing as a 'free lunch.' Someone must pay. The costs of national health insurance will be more than any of us can ever afford.

"The American public should not be misled by promises made that cannot be kept."

In his closing remarks, Dr. Perry pointed again to various government programs, concluding *"one would think we would learn our history lesson."*

Editor's note: Quite a few other Georgia physicians took time out of their practices to appear at these hearings, both in Atlanta and in Albany. Summaries of some of their statements will be featured in the January issue of the *Journal*.



METROPOLITAN PSYCHIATRIC

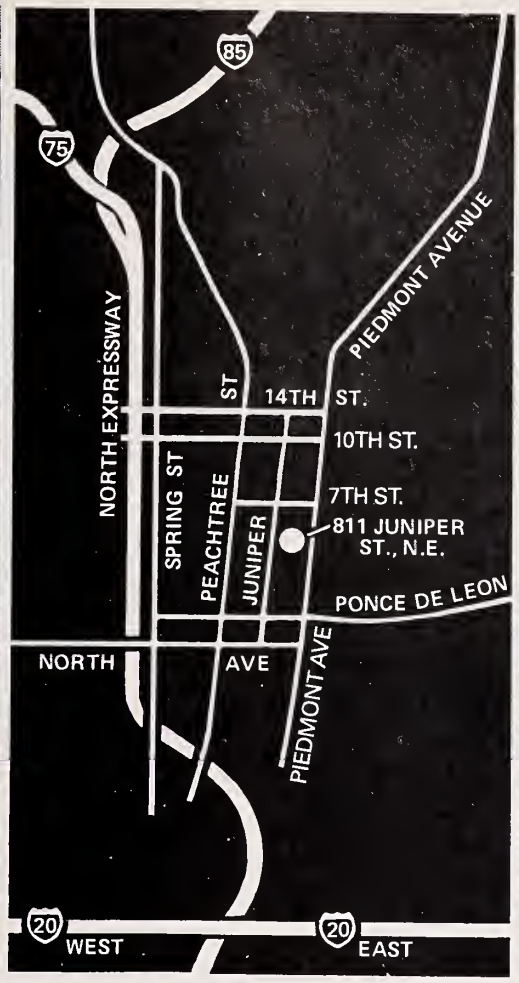
METROPOLITAN PSYCHIATRIC CENTER, centrally located in midtown Atlanta, provides comprehensive services for adult and adolescent patients in the area psychiatry and alcohol and drugs. Inpatient care, outpatient care and partial hospitalization programs available at the Center.

In the Psychiatric Program, the attending psychiatrist determines from the comprehensive services available the most appropriate modality(s) of treatment, but always within the theme of individualized care.

The following services are available through the psychiatric program:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy







CENTER

mily Counseling
ychological Testing
cial Work Services
lucational Tutoring
cational Rehabilitation Counseling
ll Radiology Services
ctivity Therapy Programs including Occupational
erapy, Recreational Therapy and Art Therapy

Georgian Clinic Program, directed towards the
very of persons addicted to alcohol or drugs, offers a
ctured yet personalized experience drawing upon a
range of treatment modalities. Through the

Grumet, M.D.
cal Director

Custis L. Rosser, M.H.A.
Administrator

ge Dominick, M. Div.
tor, Georgian Clinic Program

combined resources of the Center for Psychotherapy Inc., the Atlanta Internal Medicine, P.A., and the Metropolitan Psychiatric Center staff, the following services are included:

- Evaluation
- Detoxification
- Group Therapy
- Individual Therapy
- Education
- Systematic Coping Skills
- Referrals for Continued Outpatient Care
- AA Information and Referral
- Vocational Rehabilitation Counseling
- Family Counseling
- Pastoral Counseling Services

Additional information on the Psychiatric Program may be obtained by contacting Dottie Fitchett, Admissions. For information on the Georgian Clinic Program, call 876-8655. METROPOLITAN PSYCHIATRIC CENTER is a member of the American Hospital Association, The Federation of American Hospitals, National Association of Private Psychiatric Hospitals, Georgia Hospital Association and the Metropolitan Atlanta Hospital Council.

opolitan Psychiatric Center accredited by the Joint Commission on Accreditation of Hospitals
Juniper Street, N.E., Atlanta, Georgia 30308/Telephone (404) 873-6151

Important.....

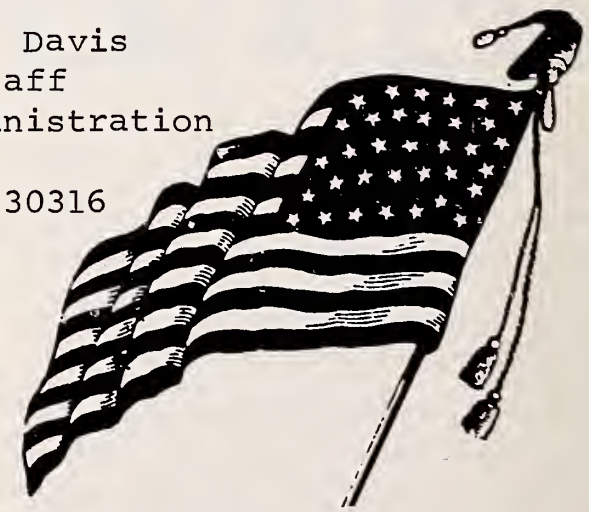
It may be a totally new experience for you or it may be the continuation of a secondary career.....

As a doctor in the Georgia Army National Guard, you can find the satisfaction that many professional and highly skilled persons have already found. . . . service to the community, state and nation.

In addition, many persons have found that the change of place and change of pace has resulted in renewed energies in their fulltime occupations. One weekend a month is the normal meeting period for Georgia Army National Guard units. These "drill" periods, as we call them, can be very flexible to suit the needs and training requirements of the unit. Physicians even receive monetary support for attending CME meetings as well as pay for other unit training assemblies and two weeks of annual training every year. WE NEED YOUR SKILLS AND WE OFFER YOU THE CHANCE TO RECEIVE THE SATISFACTION FROM SERVICE TO YOUR FELLOW CITIZENS. If you need that CHANGE OF PLACE and CHANGE OF PACE, contact



Colonel William M. Davis
Deputy Chief of Staff
Personnel and Administration
PO Box 17965
Atlanta, Georgia 30316
404-656-6662



When pain complicates acute cystitis*

Azo Gantanol®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl

for the pain for the pathogens



□ **Early relief of painful symptoms** such as burning and pain associated with urgency and frequency.

□ **Effective control of susceptible pathogens** such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

□ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

*Nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: **Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

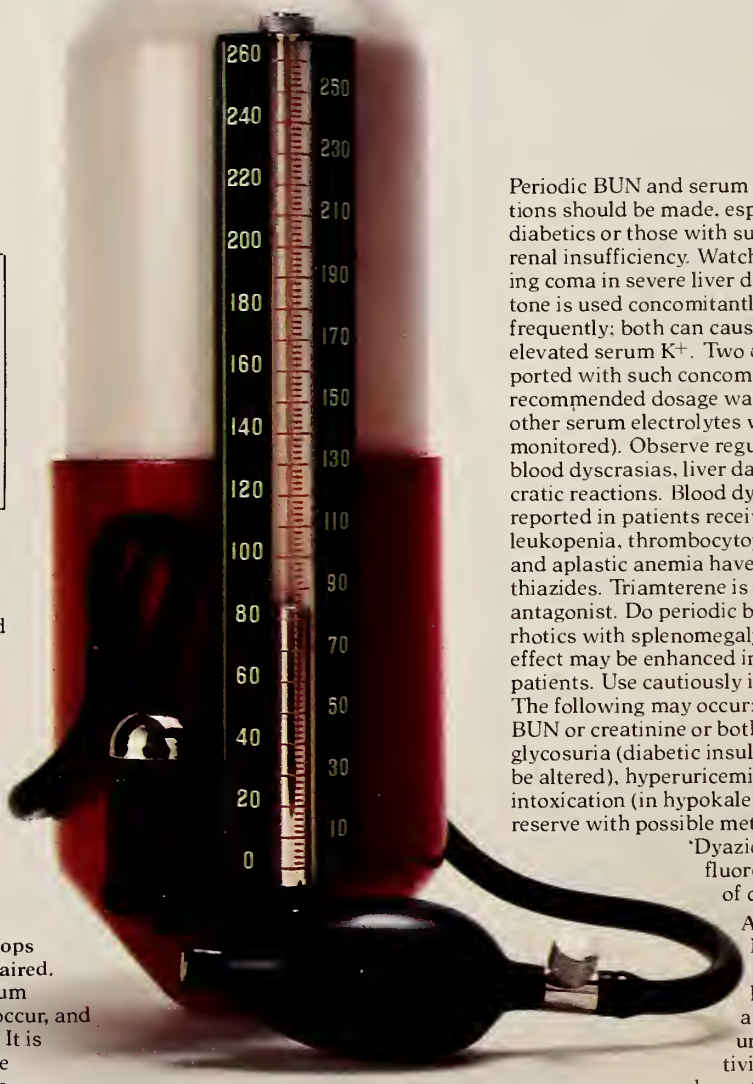
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* **Warning**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

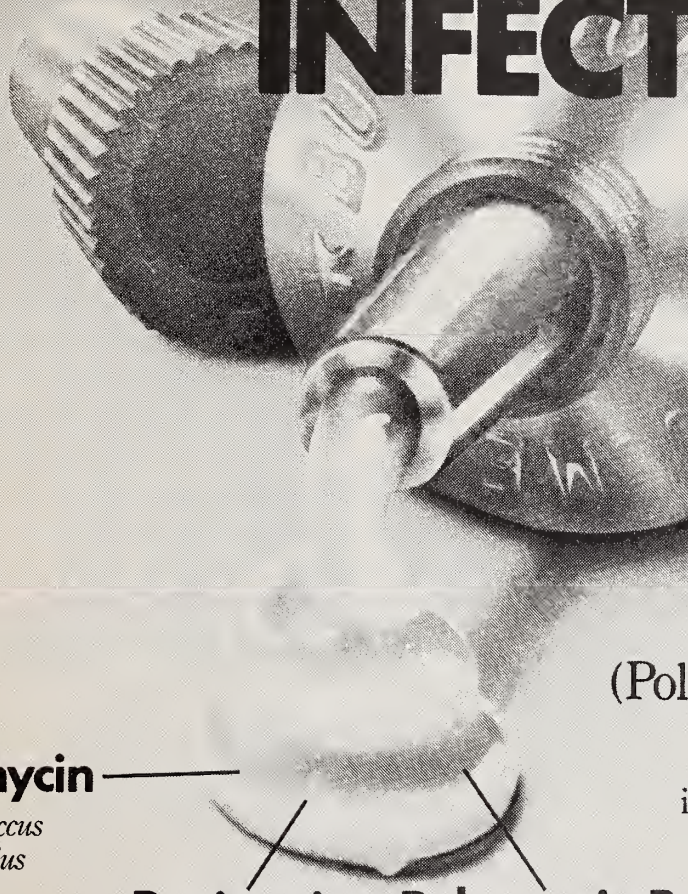
Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K^+ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome / **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

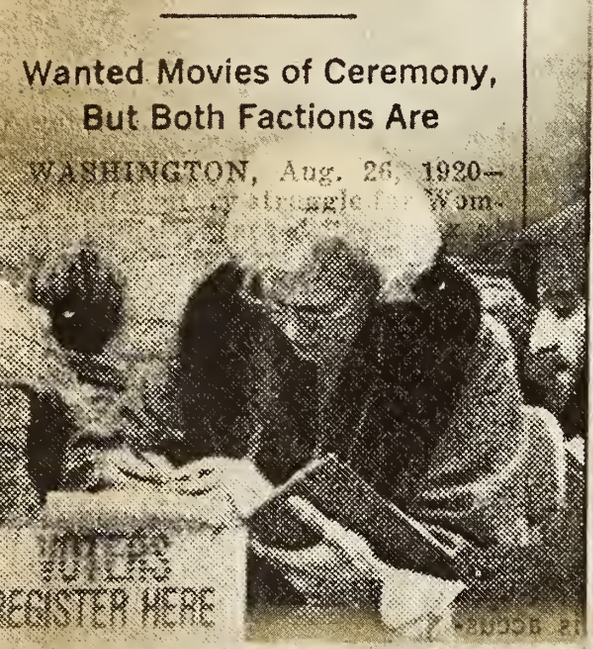
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws–He Ca the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pen and counted upon to benefit 20,000,000 persons, became la day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Co

Mr. Roosevelt cal me "the cor erstone stru which is being m s comple rin to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 84 to 0 and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President presented the

SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

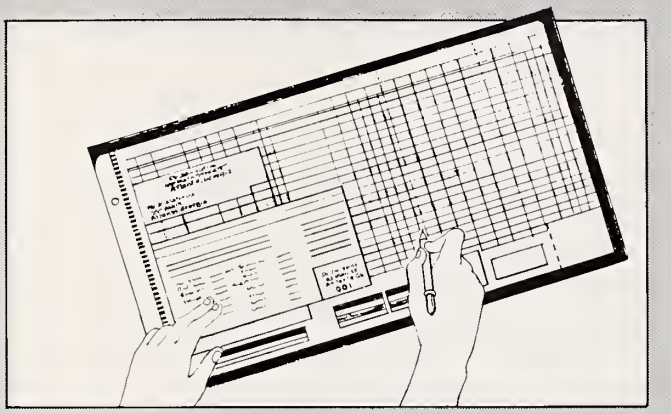
The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W., WASHINGTON, D. C. 20005

WHAT ACCOUNTING SYSTEM IS BEST FOR YOU?

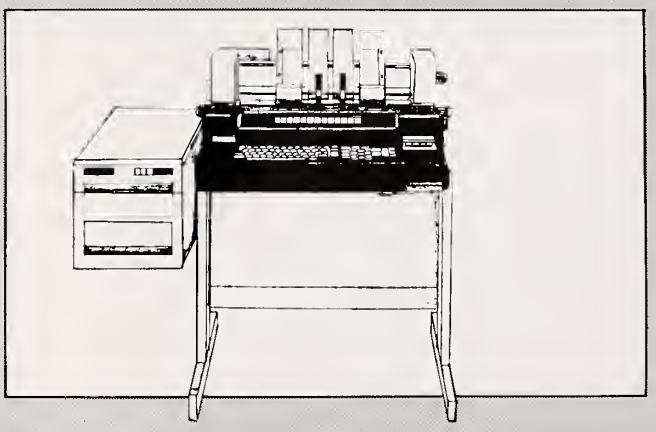
Accounting Systems Company, Inc., specialists in office efficiency systems for the medical office, wants to be your systems company.



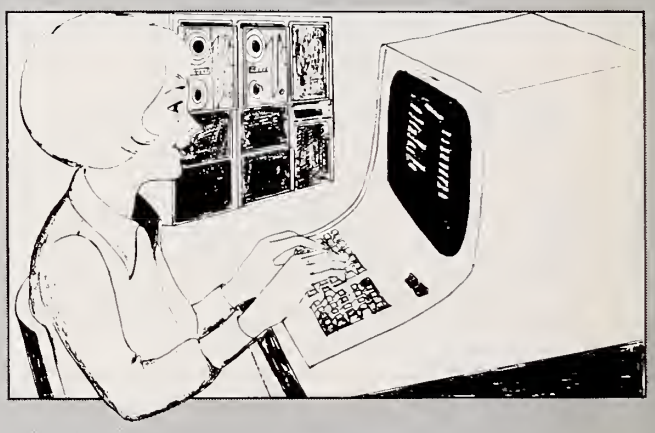
PEGBOARD: Due to its low initial cost and ease of operation, the pegboard or "one-write" system is used by more medical offices than any other system. Ideal for new and small practices.



OLIVETTI A-4: As your practice grows and your accounting needs become more time consuming and complex, the A-4 offers you greater accuracy and neatness with greater posting efficiency. We call the A-4 "The Automatic Pegboard".



OLIVETTI A-6: Small and medium size groups like the unique ability of our A-6 ledger oriented mini-computer. Here we have the best of both worlds; the ability to maintain an in-office ledger card and the advantages of a computer. Daily insurance preparation, month-end statements, and past-due analysis are but a few of the A-6's capabilities.



COMPUTER: Both service bureau and in-house capabilities. Our "on-line, real-time, part-time" service bureau approach to solving the problems in the medical office have been proclaimed "two years ahead of our competition" by our clients. Programs have been developed to meet the specific needs of your office.

Other products and services developed for the medical office are: Color-coded filing, alphabetical and numerical; Lateral, mobile and rotary shelving; Cross reference systems; Micro-film billing services; and Nation-wide collection services.

ASC has representatives through-out the southeast who are ready and able to help you with your system needs. It makes sense to deal with "The Specialists". Write or call today!

ACCOUNTING SYSTEMS COMPANY, INC.

P.O. BOX 216, FAYETTEVILLE, GEORGIA 30214, TEL: (404) 461-6083

Classifieds

RATES AND DATA: Space in this section is sold on a per-word basis as follows: **Members**—$5.00 for the first 50 words; $.10 per word for each additional word. **Non-members**—$15.00 for the first 50 words; $.10 per word for each additional word. *Charges are payable in advance.* Copy must be typed and received by the Publisher no later than the 25th of the month preceding publication. Blind box numbers are available at an additional charge of $1.00 per insertion. For more information, contact the Managing Editor at 938 Peachtree St., NE, Atlanta, Ga. 30309, telephone (404) 876-7535, INWATS in Georgia (800) 282-0224.

PHYSICIANS NEEDED

FULL-TIME MEDICAL DIRECTOR NEEDED. Skilled care nursing home in Southeastern United States; state-supported, medical college affiliated, 184 beds. Family Practice, General Practice or Internal Medicine background desirable. Position requires clinical practice and administrative responsibilities. Opportunities for faculty appointment, teaching and substantial benefits are available. Contact Administrator, Georgia War Veterans Nursing Home, 1101 15th Street, Augusta, Georgia 30901. Phone (404) 828-2531. An Equal Opportunity, Affirmative Action Employer.

FAMILY PRACTICE AND OB/GYN opportunity for solo or group practice in community of approximately 9,000 located in east-central section of South Carolina. Partnership arrangement guarantees $50,000. Forty-eight-bed hospital serves local area with easy access and referral to new regional medical center 20 miles away. Six FPs/GPs presently in community. Contact J. D. Whitehead, M.D., Lake City, S.C., (803) 394-2238.

REAL ESTATE

DESIRABLE SUBLEASE in Northwest Medical Center, a building adjacent to West Pace's Ferry Hospital and Metropolitan Eye Hospital; 1,132 square feet with northwest exposure. Rate negotiable. No charge for existing tenant improvements. Write Box 10-B c/o the *Journal*.

WILL SELL, IN WHOLE OR PART, 95 acres of farmland, West Cobb County near MacLand; 25-29% down, balance on any reasonable terms. Write: Physician, P.O. Box 54778, Atlanta, Ga. 30308.

MEDICAL OFFICE SPACE TO SHARE with established GP, internist. Ideal location, busy intersection in east Marietta near I-285 and I-75. Will consider part-time or full-time. No investment required. Very suitable for second office in such fields as ophthalmology, dermatology, pediatrics, Ob-Gyn, podiatry, radiology or laboratory. Ability to expand office if needed. Call (404) 973-8300.

BEAUTIFUL GLASS PAVILION HOUSE for sale with 8 acres of land north of Atlanta. Only home like this in the state. Huge great-room; three fireplaces, one in massive kitchen; full studded basement. Call (404) 993-4260.

SERVICES

PHYSICIANS AUTO LEASING SERVICE. A state-wide leasing service is offered to physicians and other health professionals. First Georgia Leasing gives preferred rates on luxury and prestige cars and leases all makes, foreign and domestic. Special rates quoted for multiple group-practice leases. Call Tom Lawless (404) 971-8838.

MISCELLANEOUS

THE GEORGIA AGRIRAMA, a non-profit State of Georgia funded restoration project of late nineteenth century life in Georgia, is in need of information, artifacts, books, etc. dealing with the practice of medicine during the time period 1870-1899. Interested parties should contact: Georgia Agrirama, P.O. Box Q, Tifton, GA 31794; (912) 386-3344. Donations are tax deductible.



JOURNAL
of the medical association of
georgia

Index
Volume 66—1977

AUTHOR INDEX

Authors	Page
Adair, M. C., M.D.	E-960
Akin, John T., Jr., M.D., F.A.C.S.	534
Allman, Fred L., Jr., M.D.	599, 836
Andrews, Russell E., Mrs.	833, 612
Appel, Sidney, M.D.	698
Atkins, Ernest C., M.D.	607, 777
Baker, J. Jay, M.D.	824
Barker, W. Daniel, F.A.C.H.A.	298
Barlow, R., M.D.	28
Beck, Leif C., C.P.B.C., LL.B.	801
Berg, Robert N.	L-907, L-973
Bernard, George R., Ph.D.	885
Berry, J. Norman, M.D.	H-235
Bohler, C. Emory	611
Bryant, Milton F., M.D.	147
Burgstiner, Carson B., M.D.	608
Cantwell, John D., M.D.	H-654
Carr, Albert A., M.D.	277
Caster, W. O., Ph.D.	947
Cates, Gerald L., Ph.D.,	23
Christy, James H., M.D.	951
Cohen, Marvyn D., M.D.	E-719
Crumbley, A. J., M.D.	635
Cunningham, Robert P., M.D.	H-35
Curtis, Ernest M., M.D.	558
Daniel, Stephen L., Ph.D.	865
D'Anna, Edward J., M.S.L.S.	89
Davies, Nicholas E., M.D.	681, 886
Davis, H. Gordon, Jr.	943
Dowda, F. William, M.D.	610
Eldridge, F. G., M.D.	610
Fechtel, Edward J., Jr.	222
Fleischer, Alan S., M.D.	151
Garrison, Glen E., M.D.	884
Giddens, Don P., Ph.D.	147
Gober, Billy, Ed.D.	880
Good, John, Ph.D.	525
Grady, Edgar D.	21, 625
Gray, Stephen W., Ph.D.	534, 542, 544
Gullen, Warren H., M.D., M.P.H., F.A.P.H.A.	783
Hagler, William S., M.D.	225
Hallman, Bernard L., M.D.	871
Harlafis, Nicholas, M.D.	534
Haverty, John Rhodes, M.D.	815
Higginbotham, Fred R.	291
Holderfield, J. W., CAE	888
Hollis, Charles D., Jr., M.D.	E-91, 609
Hudson, John A., M.D.	870
Huff, J. Winston	L-739
Kalogredis, Vastilios J., J.D.	801
Johnson, Henry C., Jr., M.D.	544
Jolley, Fleming L., M.D.	34, 94, 162, 609
Kanto, William P., Jr., M.D.	616
Kaufmann, James A., M.D.	217
Kellum, J. Morgan, M.D.	33, 568
Kidd, Rusty	217
Killingsworth, Scott	L-237
Lee, J. Moultrie, M.D.	C-967
Lesser, Laurence, M.D.	85
Linkous, William, Jr.	L-102
Love, Daryll	L-328
Leigh, Ted F., M.D.	897
Manchester, Thomas P., M.D.	225
Marzetti, Philip J.	L-171
Maughon, James S., M.D.	869
Mauldin, John T., M.D.	155
McDaniel, J. G., M.D.	105, 160, 231, 304, 640, 727, 823, 965
McFadden, Louisa W., M.S.W., ACSW	857
McFarland, Kay W., M.D.	277
McGinnis, LaMar S., M.D.	891
McLanahan, C. Scott, M.D.	951
McNamara, Virginia, M.D.	689
Merrill, Arthur J., Jr., M.D.	323
Miller, Gordon C., M.D.	H-903, H-969
Mims, Carol, R.N.	17
Mitchell, William E., Jr., M.D.	17
Moore, W. W., M.D.	610
Morris, Douglas C., M.D.	572
Mosher, Charles B., M.D.	87
Murphy, C., M.D.	28
Murphy, Gerald P., M.D.	C-233
Neuman, Eric P.	L-102
Nolan, Thomas R., M.D.	625
Patton, Robert M., M.D.	H-737
Pendergrast, William J., M.D.	98
Perry, Robert E., Jr., M.D.	230, 361, 492, 567, 608, 642, 725, 819, 892, 963
Raines, Jack A., M.D.	816
Ravry, Mario, Jr., M.D.	C-163, 220, C-899
Resurreccion, Anna V. A., Ph.D.	947
Richard, Douglass M.	302
Richardson, A. Cullen, Jr., M.D.	777
Riley, Wells, M.D.	943
Rinaldi, Ann, R.N.	525
Robertson, Alex F., III, M.D.	616
Rogers, Harrison L., Jr., M.D.	E-158, 288, 639
Rosen, A. R., M.D.	625
Rowell, Roger R., M.D.	E-228
Ryan, Alan J., M.D.	836
Sammons, James H., M.D.	633
Scoggin, W. A., M.D.	689
Siegel, David W.	L-171
Silverman, Mark E., M.D.	525
Skandalakis, John E., M.D., Ph.D., F.A.C.S.	534, 544
Sorg, Jack, M.D.	519, 558
Sullivan, James H., M.D.	713
Sullivan, Louis, M.D.	882
Talbott, G. Douglas, M.D.	777
Tift, William Lee, M.D.	703
Tindall, George T., M.D.	151, 951
Turner, Joe M., M.D.	H-100
Van Buren, James K., M.D.	E-31
Vincent, Richard H.	L-38, L-577, L-644, L-829, L-973
Watson, David T., M.D.	17
Wenger, Nanette K., M.D.	85
Whitaker, William G., Jr., M.D.	519
Wilber, Joseph A., M.D.	E-313
Wieland, William F., M.D.	861
Winokur, Stanley	C-729
Witham, A. C., M.D.	E-637
Whitlock, Richard R., M.D.	277
Woody, Edgar A., Jr., M.D.	E-93, E-159, E-312, E-565, E-639, E-959
Youngerman, Robert A.	141

Month	Pages
January	1- 54
February	55- 126
March	127- 202
April	203- 262
May	263- 346
June	347- 510
July	511- 590
August	591- 672
September	673- 754
October	755- 844
November	845- 928
December	929-1002

Key to abbreviations appearing before page numbers:

C—Cancer Page
E—Editorial
H—Heart Page
L—Legal Page

SUBJECT INDEX

— A —

ADDICTION/ALCOHOLISM
The Impaired Physicians Conference (Talbott) 314
The MAG Disabled Doctors' Program: A Two-Year Review (Talbott, Richardson, Atkins) 777
A New Model for Inpatient Treatment of Alcohol and Other Drug Addictions (Wieland) 861

ADENOCARCINOMA
Primary Adenocarcinoma in an Elongated Fallopian Tube (Sorg, Curtis) 558

AHLQUIST
Ahlquist, Basic Research and the Practice of Medicine (Witham) E-637

AMERICAN MEDICAL ASSOCIATION
Report on Clinical Meeting of AMA 95
Students Introduced to Organized Medicine 97
Harrison L. Rogers 157, E-639
MD Vacancies in Project USA 170

ANGIOGRAPHY
Current Indications for Coronary Artery Angiography and Bypass Surgery (Miller) (Part 1) H-903
Current indications for Coronary Artery Angiography and Bypass Surgery (Miller) (Part 2) H-969

ANTIBIOTICS
Hospital Acquired Infections and Antibiotic Sensitivity (Mitchell, Mims, Watson) 17

ANTIDYSTHANASIA
The California Natural Death Act—Some Help With Antidysthanasia (Vincent) L-38

ATHEROSCLEROSIS
Blood Flow Studies Following Carotid Endarterectomy, Cervical Sympathectomy and Ligation of the External Carotid Artery (Bryant, Giddens) 147

— B —

BIOPSY
Percutaneous Biopsy of the Liver Using A New Disposable Needle (Ravry) . 220

— C —

CANCER
Toll-Free Cancer Line Open 166
Internal Radiation Therapy of Liver Cancer (Grady, Nolan, Rosen) ... 625
(See also, CANCER PAGE)

CANCER PAGE
Carcinoembryonic Antigen (CEA) (Ravry) C-899
The Changing Picture of Malignant Melanoma (Pendergrast) C-98
Help Is Available in Care of Your Patient With Cancer (Lee) C-967
Hormonal Therapy of Breast Cancer (Baker) C-824
Recent Developments in Cancer Chemotherapy (Winokur) C-729
Report on Liver Tumors and Oral Contraceptives (Murphy) C-233
Summary Statement from Workshop on Late Effects of Irradiation to the Head and Neck in Infancy and Childhood C-319
Tempest in the "Sugar" Bowl C-571
Testing Stool for Occult Blood to Detect Asymptomatic Large Bowel Cancer (Ravry) C-163

CARDIOLOGY
Blood Flow Studies Following Carotid Endarterectomy, Cervical Sympathectomy and Ligation of the External Carotid Artery (Bryant, Giddens) .. 147
Saturated Animal Fat, Plasma Cholesterol and Coronary Heart Disease (Caster, Resurreccion) 947
(See also, HEART PAGE)

CEREBRAL ANEURYSMS
Preoperative Treatment of Ruptured Cerebral Aneurysms (Fleischer, Tindall) 151

CERVICAL SYMPATHECTOMY
Blood Flow Studies Following Carotid Endarterectomy, Cervical Sympathectomy and Ligation of the External Carotid Artery (Bryant, Giddens) .. 147

CHEMOTHERAPY
Recent Revelopments in Cancer Chemotherapy (Winokur) C-729

CHILD ABUSE
Liaison Between Physicians and Social Workers (McFadden) 857

COLON CANCER
Role of Diet in the Etiology of Colon Cancer (Gullen) 783

CONTRACEPTIVES
Contraceptive Usage and Other Characteristics of 440 Pregnant Teenage Patients at MCG in 1975 (McNamara, Scoggin) 689
Report on Liver Tumors and Oral Contraceptives (Murphy) 233

CONTINUING MEDICAL EDUCATION
Accredited CME in Georgia 873
The Case Against Mandatory CME (Wells) 877
Continuing Medical Education by TV Broadcasts and Videocassettes: The Emory Program (Hallman) 871
Continuing Medical Education at MCG (Garrison) 884
How Does an Organization Obtain Category 1 Credits for Its CME Programs (Maughon) 869
MAG to Conduct Survey on CME ... 872
The MAG and Education: An Update (Daniel) 865
Preparing an Education Program in a Community Hospital (Hudson) 870

COST OF HEALTH CARE
The Anatomy of Hospital Costs (Barker) 298
Breakdown on DMA Expenditures (Jolley) 919
Carter Hospital Control Plan Labeled Threat to Patients 301
Cost Containment—At All Costs! (Rogers) 288
Government Involvement in Health Care Benefits None, Says Nobel Prize Winner 301
Health Care Costs—Quo Vadis (Higgenbotham) 291
Medical Costs: Why Not A Speakers Bureau? (Woody) E-159
National Health Insurance (Sullivan) . 713
Quality Care Comes First (Perry) 315
Report on MAG's Committee on Cost Accountability (Rogers) 282
Responsible Restraint—A Key to Cost Control (Woody) E-312
Rising Costs: Private Medicine's Vulnerable Spot 92
Wake Up, Doc! (Richard) 302

CYSTOID MACULAR EDEMA
Cystoid Macular Edema after Intracapsular Cataract Extraction and Phacoemulsification 225

— D —

DEATHS
Ackerman, Elliott A. 835
Adams, J. Fred 42
Anderson, John M. 664
Bedingfield, William Osler 564
Billings, Jordan E. 495
Brantley, James G. 496
Campbell, Leonard H. 243
Coker, Grady Newton, Sr. 175
Darby, Virgil L. 107
Durham, Bon M. 107
Goodwin, Thomas W. 496
Jones, Herman D. 243
Jordan, Willis P., Sr. 496
Lewis, E. Earle 42
Long, Stewart M. 665
Lupo, Carl W. 835
Mayo, Earl A., Jr. 665
McCurdy, Willis T. 665
Middlebrooks, Tracey W. 42
Nuttall, Robert B. 243
Peterson, Thomas A. 497
Pierotti, Julius V. 108
Reith, Paul L. 665
Rodriguez, Humberto 665
Scoggins, Paul T. 835
Shuman, Rick S. 918
Smoot, Richard H. 918
Teh, Benghi 497
Thomason, W. L. 835
Veverka, Frank 175
Virusky, Edmund J. 243
Venable, John H. 743
Walker, John R. 497
Waxler, Edward B. 585
Woodward, Jimmy G. 835

DISABLED DOCTORS
The Impaired Physicians Conference (Talbott) 314
The MAG Disabled Doctors' Program: A Two-Year Review (Talbott, Richardson, Atkins) 777

DISTRIBUTION OF PHYSICIANS
Access to Health Care Committee at Work E-961
Physician Recruitment Conference/Pre-Practice Seminar 983
Primary Care Physician Manpower Study: Present and Projected Need (Riley, Davis) 943

— E —

EDITORIALS
Access to Health Care Committee at Work (Adair) E-960
Ahlquist, Basic Research, and the Practice of Medicine (Witham) E-637
Delineation of Fees According to Geographical Areas (Hollis) E-91
Election of MAG Officers E-488
Enjoy Your Stay in Macon (Smisson) E-84
Harrison Rogers, Vice Speaker (Woody) E-639
HSAs: Black Hats or White Hats? (Rogers) E-158
High Blood Pressure Month: Treatment Is the Theme (Wilber) E-313
MAGNET 77—Is This the Answer? (Cohen) E-719
Medical Costs: Why Not A Speakers' Bureau? (Woody) E-159
MAG 1977 (Woody) E-959
MAG Committee Helps Improve Jail Conditions (Haverty) E-815
New Managing Editor for the Journal (Woody) E-93
Piedmont, a Community Hospitial, Alive and Well (Woody) E-565
Opsimathy and Other Responsibilities (McGinnis) E-891
Politics and the AMA: What They Mean to You E-30
Reflections on the MAG Scientific Assembly 1976 (Van Buren) E-31
Responsible Restraint—A Key to Cost Control (Woody) E-312
Ophthalmologists and MAG Join Forces (Rowell) E-229
Rising Costs: Private Medicine's Vulnerable Spot E-92
Thanks to Everyone (Rogers) E-639
Will We Ever Learn (Raines) E-816

EDUCATION
Education: A Primary Goal (Perry) .. 892
A Health Screening Clinic (Grady) .. 21
Opsimathy and Other Responsibilities (McGinnis) 891
Televised Patient Education in a Community Hospital (Rinaldi, Good, Silverman) 525
MAG Sponsors Education for Residents (Daniel) 227
(See also, MEDICAL SCHOOLS, CONTINUING MEDICAL EDUCATION, PUBLIC EDUCATION)

EMERGENCY MEDICINE
Pre-Hospital Emergency Care in Georgia: A Status Report (Mosher) 87
Update on Metropolitan Emergency Medical Services (MEMS) (Berry) H-235
When It's Heart Attack, Every Minute Counts H-100

EXERCISE
Current Concepts: Exercise and Coronary Disease (Cantwell) H-654

— G —

GASTROENTEROLOGY
Percutaneous Biopsy of the Liver Using A New Disposable Needle (Ravry) . 220
Volvulus of the Right Colon in the postpartum and Postoperative Patient (Sorg, Whitaker, Richmond) 519
The Pattern of Intussusception in Adults (Harlaftis, Skandalakis, Droulias, Gray, Akin) 534
Antral and Pyloric Mucosal Diaphragm in Adults (Gray, Skandalakis, Johnson) 544
Role of Diet in the Etiology of Colon Cancer (Gullen) 783

GOVERNMENT AND THE PHYSICIAN
1977 Legislative Round-Up (Kaufmann, Kidd) 217
Government Involvement in Health Care Benefits None Says Nobel Prize Winner 301
Wake Up, Doc! (Richard) 302
(See also, LEGAL PAGE)

GYNECOLOGY
Primary Adenocarcinoma in an Elongated Fallopian Tube (Sorg, Curtis) 558

— H —

HEALTH MAINTENANCE ORGANIZATIONS
Federal Health Maintenance Organization Amendments of 1976 (Killingworth) L-237

HEALTH SYSTEMS AGENCIES
HSAs: Black Hats or White Hats? (Rogers) E-158
HSAs: Danger Lies Ahead (Perry) .. 725
Progress of the North Central Georgia Health Systems Agency (Youngerman) 141

HEART PAGE
Cardiopulmonary Resuscitation: The Challenge and How It Is Being Met (Cunningham) H-35
Current Concepts: Exercise and Coronary Discase (Cantwell) H-654
Current Indications for Coronary Artery Angiography and Bypass Surgery (Miller) (Part 2) H-969
Current Indications for Coronary Artery Angiography and Bypass Surgery (Miller) (Part 2) ....
The Evolution of Prosthetic Heart Valves (Morris) H-572
Heart Bypass Operations Top 1,000 Mark at Emory H-101
Management of Congenital Ventricular Septal Defect (Williams) H-167
New Format: Your Participation Is Requested (Patton) H-737
Update on Mctropolitan Emergency Medical Services (MEMS) (Berry) H-235
Vasodilators: An Advance in Management of Congestive Heart Failure (Merrill) H-323

When It's Heart Attack Every Minute Counts (Turner) H-100
HERNIA
A Method of Hernia Repair (Appel) . 698
HISTORY OF MEDICINE
A Few Essentials for a Successful Medical Society (1927 *Journal*) 657
The Greek Healers: Asklepios, Hippocrates and Hygieia (Gray) 542
Thomsonian Medicine and Early Georgia Medical Societies (Cates) 23
HOLTER MONITOR
Three Causes of Syncope of One Patient, Detected by Holter Monitoring (Lesser, Wenger) 85
HORMONAL THERAPY
Hormonal Therapy of Breast Cancer (Baker) C-824
HOSPITAL ADMINISTRATION
Decision Making in Health Care (Fechtel) 222
HOSPITAL INFECTIONS
Hospital Acquired Infections and Antibiotic Sensitivity (Mitchell, Watson, Mims) 17
HYPERTENSION
High Blood Pressure Month: Treatment Is the Theme (Wilber) E-313

— I —

INFECTIOUS DISEASES
Group B Streptococcal Infections in the Neonate 703
Hospital Acquired Infections and Antibiotic Sensitivity (Mitchell, Mims, Watson) 17
INFORMED CONSENT
Informed Consent—Georgia Update (Huff) L-739
INSURANCE
MAG Self-Funded Trust (Mauldin) .. 155
INTUSSUSCEPTION
The Pattern of Intussusception in Adults (Harlaftis, Skandalakis, Droulias, Gray, Akin) 534
ISCHEMIC ATTACKS
Transient Ischemic Attacks: Is Medical Therapy Efficacious? (Whitlock, McFarland, Carr) 277
I'VE TOLD THIS BEFORE
An Act of Courage (McDaniel) 965
Called on the Carpet, But Not Electrocuted (Kellum) 568
Caution Was the Watch Word (Kellum) 33
A Cruel Man (McDaniel) 640
Flag Man at the Nursing Home (McDaniel) 231
Horace the Mule (McDaniel) 820
How to Give Your Wife a Pep Shot Without A Needle (McDaniel) 727
Navy Lieutenant on a Train (McDaniel) 160
A Retiree's Lunch (McDaniel) 105
Those Impish Little Devils (McDaniel) 304
The Thoughts of Sweet Alice (Leigh) . 897

— J —

JAILS
MAG Committee Helps Improve Jail Conditions (Haverty) 815

— L —

LEGAL PAGE
Antitrust and the Health Industry—Straws in the Wind (Vincent, Teplin) L-644
The California Natural Death Act—Some Help with Antidysthanasia (Vincent) L-38
Federal Health Maintenance Organization Amendments of 1976 (Killingsworth) L-237
Informed Consent—Georgia Update (Huff) L-739
Medicare and Medicaid: Anti-Fraud and Abuse Amendments (Vincent, Berg) L-973
Regents of the University of California v. Bakke: Must Medical School Admissions Programs Be "Color-Blind?" (Berg) L-907
Significant Income Tax—Changes in the New Tax Law (Siegel, Marzetti) .. L-171
So You Want to Counterclaim (Love) L-328
The Staff Physician's Negligence: When Is the Hospital Liable? (Vincent, Stodghill) L-829
Voluntary Binding Arbitration of Medical Malpractice Disputes in Georgia —Possibilities for New Legislation (Vincent) L-577
Estate Planning Aspects of the Tax Reform Act of 1976 (Linkous, Neuman) L-102
LIBRARIES
The Addison M. Duvall Library May Be Able to Help You (D'Anna) .. 89
The Future of Small Hospital Libraries (Davies) 681
LIVER
Internal Radiation Therapy of Liver Cancer (Grady, Nolan, Rosen) 625
Percutaneous Biopsy of the Liver Using A New Disposable Needle (Ravry) .. 220
Report on Liver Tumors and Oral Contraceptives (Murphy) C-233
LIVER BIOPSY
Percutaneous Biopsy of the Liver Using a New Disposable Needle (Ravry) . 220

— M —

MALPRACTICE
Voluntary Binding Arbitration of Medical Malpractice Suits in Georgia—Possibilities of New Legislation (Vincent) L-577
So You Want to Counterclaim (Love) L-328
Will We Ever Learn? (Raines) 816
MEDICAL ASSOCIATION OF GEORGIA
ACTIVITIES
1977 Legislative Roundup (Kaufmann, Kidd) 217
Access to Health Care Committee at Work (Adair) E-960
Accredited CME in Georgia 873
Harrison L. Rogers 157
The Impaired Physicians Conference 314
MAG Committee Helps Improve Jail Conditions (Haverty) 815
MAG to Conduct Survey on CME . 872
The MAG Disabled Doctors' Program: A Two-Year Review (Talbott, Richardson, Atkins) 777
The MAG and Education: An Update (Daniel) 865
MAGNET '77: An Overwhelming Success 981
MAG Self-Funded Trust (Mauldin) 155
Ophthalmologists and MAG Join Forces (Rowell) 229
Physicians Recruitment Conference/Pre-Practice Seminar 983
Report from MAG's Committee on Cost Accountability (Rogers) ... 282
Students Introduced to Organized Medicine 97
Thanks to Everyone (Rogers) E-639
ANNUAL SESSION
Official Call 73
Officials of the Association 1976-77 . 75
Component County Society Representation to 1977 House of Delegates Official Program 78
Criteria for Selection of Recipients of MAG Awards 77
Auxiliary 52nd Annual Convention Greetings & Schedule (Andrews) . 80
Enjoy Your Stay in Macon 83, 84
Official Proceedings:
Proceedings Index 355
Highlights of the 1977 Annual Session 358
MAG First General Session 361
First Session, House of Delegates 365
GaMPAC Brunch 389
Second Session, House of Delegates 390
MAG Final General Session 485
DEATHS
42, 107, 175, 243, 495, 585, 664, 743, 835, 918
JOURNAL
Letters to the Editor . 173, 316, 566, 978
New Personnel 93, 979
NEW MEMBERS
41, 106, 174, 242, 331, 495, 583, 663, 743, 831, 917, ...
PERSONALS
41, 107, 174, 243, 332, 583, 663, 743, 832, 917, 977
PRESIDENT'S LETTER
Annual Session Successful (Perry) .. 492
Congratulations to Harrison Rogers (Perry) 642
Don't Forget Our Purpose (Perry) .. 230
Education: A Primary Goal (Perry) 892
Happy Holidays (Perry) 963
HSAs: Danger Lies Ahead (Perry) 725
Let Me Hear From You (Jolley) .. 94
MAG Will Help You With PSRO (Perry) 819
Not A Game, Just Communicating (Jolley) 34
Quality Care Comes First (Perry) 315
Some Closing Remarks (Jolley) ... 162
1977 Scientific Assembly (Perry) .. 567
SCIENTIFIC ASSEMBLY
1977 Scientific Assembly (Perry) .. 567
Scientific Assembly Program 766-775
Reflections on the MAG, Scientific Assembly, 1976 31
Report on the 1976 Scientific Assembly 32
SOCIETIES
41, 107, 174, 242, 331, 495, 832, 917, 977
MEDICAL SCHOOLS
Continuing Medical Education at MCG (Garrison) 882
Continuing Medical Education by TV Broadcasts and Videocassettes: The Emory Program (Hallman) 871
The School of Medicine at Mercer University: An Update (Bernard) 885
The School of Medicine at Morehouse College: A Progress Report (Sullivan) 882
MEDICARE/MEDICAID
Ask Medicare 29, 99, 224
Delineation of Fees According to Geographical Areas (Hollis) 91
Medicare and Medicaid: Anti-Fraud and Abuse Amendments (Berg, Vincent) L-973
MENTAL HEALTH
The Addison M. Duval Library May Be Able to Help You (D'Anna) 89
MELANOMA
The Changing Picture of Malignant Melanoma C-98
MONTH IN WASHINGTON
43, 176, 245, 337
MUCOSAL DIAPHRAGM
Antral and Pyloric Mucosal Diaphragm in Adults (Gray, Johnson, Skandalakis) 544

— N —

NATIONAL HEALTH INSURANCE
Congress of County Medical Societies Seminars 949
HEW Hearings 985
National Health Insurance (Sullivan) . 713
NATURAL DEATH ACT
The California Natural Death Act-Some Help With Antidysthanasia (Vincent) L-38
NEONATAL CARE
Group B Streptococcal Infections in the Neonate (Tift) 703
One Year's Experience of a Regional Neonatal Intensive Care Unit (Kanto, Robertson) 616
NEUROLOGY
Transient Ischemic Attacks: Is Medical Therapy Efficacious? (Whitlock, McFarland, Carr) 277
Transsphenoidal Microsurgery for Pituitary Tumors (Tindall, McLanahan, Christy) 951
(See also, NEUROSURGERY)
NEUROSURGERY
Preoperative Treatment of Ruptured Cerebral Aneurysms (Fleischer, Tindall) 151
NUTRITION
Saturated Animal Fat, Plasma and Coronary Heart Disease (Caster, Resurreccion) 947

— O —

OBSTETRICS
Contraceptive Usage and Other Characteristics of 440 Pregnant Teenage Patients at MCG in 1975 (McNamara, Scoggin) 689
A "Snow-Storm" Ultrasound Pattern in the Uterus (Murphy, Barlow) .. 28
OPHTHALMOLOGY
Cystoid Macular Edema after Intracapsular Cataract Extraction and Phacoemulsification (Hagler, Manchester) 225
Ophthalmologists and MAG Join Forces (Rowell) 229

— P —

PEDIATRICS
Group B Streptococcal Infections in the Neonate (Tift) 703
One Year's Experience of a Regional Neonatal Intensive Care Unit (Kanto, Robertson) 616

PHARMACOLOGY
Ahlquist, Basic Research and the Practice of Medicine (Witham) E-637
PITUITARY TUMORS
Transphenoidal Microsurgery for Pituitary Tumors (Tindall, McLanahan, Christy) 951
POSTOPERATIVE
Volvulus of the Right Colon in the Postpartum and Postoperative Patient (Sorg, Whitaker, Richmond) .. 519
PRACTICE MANAGEMENT
Decision Making in Health Care (Fechtel) 222
Managing Your Time Through Effective Office Practice Scheduling (Beck, Kalogredis) 801
Would A Computer Help Your Practice? 791
Your Office Can Have Good Collections! 805
PROPRANOLOL
Ahlquist, Basic Research, and the Practice of Medicine (Witham) E-637
PROSTHETIC HEART VALVES
The Evolution of Prosthetic Heart Valves (Morris) 572
PUBLIC EDUCATION
Cobb County Medical Society Symposium 887
The Day the Doctor Brought A Cow to School (Gober) 880
Dougherty County Public Information Efforts 887
Educating the Public about Health and Disease: The Atlanta Health Forums, 1977 (Davies) 886
A Health Screening Clinic (Grady) .. 21
Tel-Med: A Progress Report (Holderfield) 889

— R —

RADIATION THERAPY
Internal Radiation Therapy of Liver Cancer (Grady, Nolan, Rosen) 625
RADIOLOGY
Effects of Irradiation to the Head and Neck in Infancy and Childhood .. C-319
RESEARCH, BASIC
Ahlquist, Basic Research and the Practice of Medicine (Witham) E-637

— S —

SACCHARIN
Tempest in the "Sugar" Bowl C-571
SPORTS MEDICINE
Immediate Evaluation of Athletic Injuries (Ryan, Allman) 836
Prevention and Recognition of Athletic Injuries (Allman) 599
STREPTOCOCCAL INFECTIONS
Group B Streptococcal Infections in the Neonate (Tift) 703
SURGERY
Antral and Pyloric Mucosal Diaphragm in Adults (Gray, Johnson, Skandalakis) 544
Cystoid Macular Edema after Intracapsular Cataract Extraction and Phacoemulsification (Hagler, Manchester) 225
A Method of Hernia Repair (Appel) 698
The Pattern of Intussusception in Adults (Harlaftis, Skandalakis, Droulias, Gray, Akin) 534
Volvulus of the Right Colon in the Postpartum and Postoperative Patient (Sorg, Whitaker, Richmond) 519
Statement by the American Medical Association on Unnecessary Surgery 633
(See also NEUROSURGERY, VASCULARSURGERY)
SYNCOPE
Three Causes of Syncope of One Patient, Detected by Holter Monitoring (Lesser, Wenger) 85

— T —

TAXES
Estate Planning Aspects of the Tax Reform Act of 1976 (Linkous, Neuman) L-102
Significant Income Tax—Changes in the New Tax Law (Siegel, Marzetti) 171
Where Your Tax Money Goes 247

— U —

ULTRASOUND
A "Snow-storm" Ultrasound Pattern in the Uterus (Murphy, Baker) 28
UNNECESSARY SURGERY
Statement by the AMA on Unncessary Surgery (Sammons) 633

— V —

VASCULAR SURGERY
Blood Flow Studies Following Carotid Endarterectomy, Cervical Sympathectomy and Ligation of the External Carotid Artery (Bryant, Giddens) .. 147
Current Indications for Coronary Artery Angiography and Bypass Surgery (Miller) (Part 1) H-903
Curent Indications for Coronary Artery Angiography and Bypass Surgery (Miller) (Part 2) H-969
The Evolution of Prosthetic Heart Valves (Morris) 572
Heart Bypass Operations Top 1,000 Mark at Emory 101
Management of Congenital Ventricular Septal Defect (Williams) 167
VASODILATORS
Vasodilators: An Advance in Management of Congestive Heart Failure (Merrill) 323
VITAMINS
Vitamin C Therapy Useful in a Genetic Disease 166
VOLVULUS
Volvulus of the Right Colon in the Post partum and Postoperative Patient (Sorg, Whitaker, Richmond) 519

First Georgia Leasing, Inc.

Write your own prescription. Our leases are tailored to your individual needs.

✓12-48 MONTH LEASES ✓EQUITY OR NON-EQUITY
✓PERSONAL OR BUSINESS USE
✓20 YEARS EXPERIENCE IN THE AUTOMOTIVE FIELD

That's Why Our Name Is "First Georgia Leasing

WE LEASE ALL MAKES FOREIGN & DOMESTIC

(404) 971-8838

PROFESSIONAL FINANCIAL PLANNING

Who needs it?

One quick test: If your annual income taxes are over $10,000, the chances are that you need to review your financial plan.

Continued inflation and recent tax laws, such as the Tax Reform Act of 1976, provide good reasons for professional evaluation at this time. The services of our firm are available for professional consultation.

M.L. Hines, CFP, President
J.C. Harmon, Vice President
P.G. Renn, CFP, CLU, Vice President

CONSOLIDATED PLANNING CORPORATION
Registered Investment Advisors
148 International Blvd., Suite 801
Atlanta, Georgia 30303
Telephone (404) 659-2920

Index to Advertising

Vol. 66 December 1977 No. 12

Accounting Systems Company, Inc. 994
Ballard Optical Company 946
Brawner Hospital 932
Burroughs Wellcome Co. 991
Capital Automobile Company 995
Classified Advertising 995
Consolidated Planning Corporation 999
Creditors Mercantile 972
Dickey-Mangham Company 950
Eager and Simpson 957
Epps Air Service, Inc. 931
Estes Surgical Supply Company 979
Executive Aviation Corporation 978
Faf Motorcars 982
Family Health Care, Inc. 984
First Georgia Leasing 999
Franz Blam Racing 979
Georgia Army National Guard 988
Global Imports 961
The Harrison Company 975
Hickman Datsun 941
Hill Crest Hospital 968
Hosmer and Associates 984
Lake Arrowhead 962, 966
Lakeview General Hospital 946
Eli Lilly and Company 942
Medical Oxygen Service, Inc. 984
Merck Sharp & Dohme 934, 935
Metropolitan Psychiatric Hospital 986, 937
New Orleans Graduate Medical Assembly 950
North DeKalb Office 976
Ortega Pharmaceutical Company 946
Peachtree Parkwood Hospital 964
Pharmaceutical Manufacturers Association 992, 993
Potter-Holden and Company 941
Practice Productivity, Inc. 950
Preferred Partnerships, Inc. 936
Professional Management 980
Qualicare, Inc. 946
Roche Laboratories 930, 939, 940, 989, 1001, 1002
Smith Kline & French 990
Systemedics of Georgia 978
U.S. Navy 938
Valley Psychiatric Hospital 938
Weight Watchers of Greater Atlanta, Inc. 938
Wellspring 982
Willingway Hospital 941

JOURNAL
of the medical association of georgia
938 Peachtree Street, NE / Atlanta, Georgia 30309

MANUSCRIPTS—Articles are accepted for publication on the condition that they are contributed solely in this **Journal.** Manuscripts should be typewritten, double-spaced, and the **original and one copy should be submitted.** Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE—Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies, and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals (underlined) with volume, page, month, day of month if weekly, and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis; **Arch. Int. Med.**, 36:434 (Dec.) 1946.

NEWS NOTES—District and county medical societies, Association members, and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS—Requests for reprints should be made directly to The Ovid Bell Press, Inc., 1201-05 Bluff Street, Fulton, Missouri 65251. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS—Illustrations, tables, etc., should **bear** the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication in excess of three average illustrations will be borne by the author, and the engraver will bill the author for this expense.

GENERAL POLICY—Authors will be given as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription, and miscellaneous matters should be sent to The Editor, 938 Peachtree Street, N.E., Atlanta, Georgia 30309.

ADVERTISING—All pharmaceutical advertising must be approved by the State Medical Journal Advertising Bureau, Inc., to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by the 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE—If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ℞

chlordiazepoxide HCl/Roche

5mg, 10mg, 25mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see following page.

THE ANXIETY-SPECIFIC

ACQUISITIONS DIVISION-SERIALS
U OF CALIF, SAN FRANCISCO
SAN FRANCISCO, CA. 94143

Since its discovery in the research laboratories at Roche, Libr
has been the object of ongoing pharmacologic and clinical investigati

The published record on Librium is enormous. So large, in fac
put it into a computer literature retrieval system to make it more acces
in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ℞
chlordiazepoxide HCl/Roche



ROCHE

*If you have a question about Librium or any other Roche product, write to Professional Services, Roche Laboratories, Nutley, New Jersey 07110.

Please see preceding page for a summary of product information.

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco
THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY
DEC 21 1978

RETURNED
DEC 18 1978

15m-6,'73(R176884)4315-A33-9

UCSF Library
3 1378 00841 1210

339718